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Supreme Court, U.S.
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No. 09-

In The

Supreme Court of the United States

BLAKE H. MOORE, MD,
et al.

Petitioners

v.

WILLIAMSBURG
REGIONAL HOSPITAL;
JOHN HALES; ET AL.

Respondents

On Petition For Writ Of Certiorari
To The United States Court of Appeals
For The Fourth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I. Whether the Hospital's action against Dr. Moore was properly a "professional review action" as contemplated by HCQIA so as to invoke consideration of that statute's qualified immunity for the Respondents.

II. Whether the trial court properly granted summary judgment to the Respondents based upon the qualified immunity conferred by HCQIA, at 42 U.S.C. § 11111 and its provisions to qualify for same at § 11112(a).

III. Whether the Hospital, against which the Petitioner's 42 U.S.C. § 1983 claim was brought, is a state actor under applicable law such that the trial court erred in dismissing that claim in lieu of granting his Cross-Motion for Summary Judgment on said claim.

IV. Whether the Petitioner's state law claims fail on the merits.

RULE 14.1(b) STATEMENT

A list of all parties to the proceeding in the court whose judgment is the subject of this petition is as follows:

Plaintiffs-Appellants and Petitioners: Blake H. Moore, MD and Kingstree Surgical Associates, LLC.

Defendants-Appellees and Respondents: Williamsburg Regional Hospital, John Hales, Breton Juberg, MD, Raymond Allen, MD, Evelyn Ansa, MD, Joel Bonaparte, MD, Bernadette Bonaparte, MD, Kenneth Johnson, MD, Steve Corey, DPM, Michelle Corey-Butterworth, DPM, Kevin Springle, MD, and Gilbertas Rimkus, MD, jointly and severally.

CORPORATE DISCLOSURE OF PETITIONER

Pursuant to Sup.Ct. R. 29.6, Kingstree Surgical Associates, LLC has no parent or publicly held company owning 10% or more of the corporation's stock.

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PETITION FOR A WRIT OF CERTIORARI

Blake H. Moore, MD (Petitioner), individually and on behalf of Kingstree Surgical Associates, LLC, petitions for a writ of certiorari to review the opinion and judgment of the U.S. Court of Appeals for the Fourth Circuit (Fourth Circuit) respecting all prior claims.

OPINIONS BELOW

The Fourth Circuit's March 12, 2009 opinion reported at 560 F.3d 166 (4th Cir.2009) is reproduced at App. A, 1a-24a.

JURISDICTION

This petition is timely under 28 U.S.C. § 2101(c) and Supreme Court Rule 13.1 because it is being filed within 90 days of the entry of the opinion and judgment sought to be reviewed when including the stay of mandate imposed after petitioning the Fourth Circuit for Rehearing and Rehearing En Banc on March 26, 2009, the latter denied on April 7, 2009.

This Court has jurisdiction to review the Fourth Circuit's judgment pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Relevant statutory provisions include 42 U.S.C. § 11101 et seq., the Health Care Quality Improvement Act of 1986 (HCQIA) and 42 U.S.C. § 1983, from the Civil Rights Act of 1871.

STATEMENT OF THE CASE

This Appeal arises from the Fourth Circuit's affirmation of a grant of summary judgment to Williamsburg Regional Hospital (WRH or Hospital) and certain Individual Defendants based upon their actions against the Petitioner being a "Professional Review Action" (PRA) as contemplated by 42 U.S.C. § 11151(9). Said holding was based upon qualified immunity under HCQIA and WRH's failure to satisfy state action requirements for purposes of § 1983, the court alternatively opining that Petitioner's state law claims failed on the merits. App. A, 9a.

In March 2003, following multiple quality of care complaints, Petitioner, Chief of Surgery, was warned to "watch your back" by WRH's Board Chairman. Petitioner's concerns *inter alia* included medical record spoliation concealing two fatal medication errors by the nursing staff (including its Director, her license sanctioned as a result) and the handling of unidentified human tissue later disposed of without examination or identification.

The following day, Petitioner's three adopted children were taken into custody by the South Carolina Department of Social Services (DSS), alleging that Petitioner's wife had imposed excessive discipline on one of their sons. As spouse, Petitioner was named by formality, the DSS Complaint served the next day on backboard of the law firm serving as attorneys for WRH, DSS, the County, and previously to Petitioner.

In September 2004, a second DSS Complaint alleging sexual misconduct by Petitioner upon his daughter was served despite two prior county investigations failing to substantiate same and his never being charged criminally. An unprecedented third DSS investigation resulted in a probable cause finding.

WRH CEO Hales (Hales), obtained the DSS Complaint by September 13, 2004, with Petitioner's clinical privileges immediately summarily suspended by Chief of Staff Juberg (Juberg), the WRH Medical Executive Committee (MEC) ratifying his action. All of this despite no quality of care issues, yet all of Petitioner's clinical privileges were suspended, the MEC never requesting abeyance of his small pediatric practice, his potentially utilizing a chaperone, or utilizing simple administrative suspension as suggested by the NPDB Guidebook, App. D, 75sa-81sa.

Petitioner's suspension was upheld on November 22, 2004, by an appointed hearing panel

(panel) despite no merits findings on DSS's allegations. Said panel contained three MEC members, two of whom had previously heard the matter in violation of the medical staff bylaws (bylaws) and state law, Petitioner unaware of same until the hearing occurred, despite earlier objection to (and removal of) at least one proposed panel physician for other reasons.

Timely appeal followed, WRH's Board upholding Petitioner's suspension in April 2005, still without findings on the DSS allegations. At that hearing he voiced objection to the panel's composition, citing case law holding that participation by MEC members previously considering such a matter was violative of [his] right to a fair hearing. *In Re Zaman*, 285 S.C. 345, 329 S.E.2d 436 (S.C. 1985).

WRH submitted a National Practitioner Data Bank (NPDB) report citing "sexual misconduct." Petitioner had no history of sexual impropriety, nor of any action against his medical license despite a quickly dismissed retaliatory 2002 Medical Board Complaint by WRH's previously sanctioned Nursing Director. The Medical Board, aware of the DSS allegations took no action. Following extensive DSS-ordered psychological testing, the couple was never opined to be pedophiles.

Following the July 2005 DSS Complaint's dismissal, WRH failed to reinstate Petitioner's

privileges. He continued unable to provide patient care, losing his referral base, his patient population, and the technical skills necessary to operate safely, thereafter being denied employment by multiple healthcare entities and licensure by other states as a result of the WRH NPDB report.

In defense of its failure to reinstate, WRH contended its prior Chief of Surgery was now a danger to patients after his resigning during a suspicious investigation (never resulting in adverse findings) at Columbia, SC's Providence Hospital. That investigation occurred after Hales telephonically engaged Providence's Chief Medical Officer (CMO), telling him "[Petitioner] is suing twenty of us." At deposition, Hales denied ever mentioning petitioner's lawsuit to the CMO, changing his testimony after being confronted with the CMO's notes.

What discussion followed the Hales-CMO conversation is speculative; Petitioner theretofore unaware of problems involving his Providence practice, contesting the recommendation that he not advance to Active Staff there. Qualified general surgeons supported his management of the few cases Providence cited, but in facing a legal balancing test, Petitioner elected to resign there in lieu of WRH being provided a defense to its failure to reinstate. His counsel was told by Providence's counsel prior to any peer review finding, that "[Petitioner] would never be allowed to practice there."

Rebutting any presumption that his peer review met HCQIA standards, Petitioner argued WRH being a state actor for purposes of 42 U.S.C. § 1983, denying him Constitutional due process. Summary judgment based primarily upon HCQIA immunity and WRH not being a state actor was granted with the Fourth Circuit affirming, opining that the allegations went to Petitioner's "competence" for purposes of his "peer review" rightfully being a PRA as contemplated by 42 U.S.C. § 11151(9).

On petition for a writ of certiorari, Petitioner, a blameless victim of misapplied peer review, has suffered retaliation for putting patients above profits. Seeking HCQIA immunity, WRH wrongly chose peer review in lieu of simply suspending Petitioner administratively pending resolution of DSS's allegations. However, to do so would have been non-reportable, failing to end his career or heap upon him the maximum dose of indignity. Despite the Fourth Circuit's holding, this was not a proper HCQIA PRA, its immunity never properly evoked, and WRH is truly a state actor for purposes of § 1983. Said holding should be reversed and all claims remanded to the District Court for further deliberation.

REASONS FOR GRANTING THE PETITION

I. The Fourth Circuit's Holding that the Hospital's Actions were Properly a

HCQIA Professional Review Action, Invoking Consideration of Qualified Immunity for the Respondents, sets a Perilous Standard for Physicians Requiring Clarification and Reversal.

HCQIA, 42 U.S.C. § 11151(9) defines a PRA as:

> **[A]n action or recommendation of a professional review body ... taken or made in the conduct of professional review activity ... based on the competence or professional conduct of an individual physician ... an action is not ... [so based] if the action is primarily based on ... (E) any other matter that does not relate to the competence or professional conduct of a physician.**

By WRH's admission, this matter involved allegations, not competence or conduct. Seizing on speculative patient injury, the Fourth Circuit recognized the "breadth of...Respondents' argument ignore[d] [HCQIA's] limiting language. App. A, 14a. Nonetheless, it opined that Petitioner's argument urged too stark a dividing line between private and professional conduct, utilizing § 11151(9)'s term "competence" to reel the DSS allegations within HCQIA's purview. *Id.*

Its interpretation begs the questions, "Was it truly Congress' intention that unproven allegations form the basis for an NPDB Report"? "Why are physicians necessary to deliberate a remedy not demanding medical expertise"? "Why do HCQIA, its implementing regulations and the NPDB Guidebook contemplate administrative suspension for matters unrelated to competence or conduct"? Cursory analysis shows that this scenario at most demanded non-punitive, unreportable administrative suspension or more reasonably monitoring of, or the abeyance of Petitioner's small pediatric practice.

The Fourth Circuit failed in not realizing that private conduct not directly implicating professional competence is the purview of administrative suspension as contemplated in the NPDB Guidebook, App. D, 75sa, HCQIA at § 11151(9)(E), and 45 C.F.R. § 60.3, not peer review. Similarly, voluntary surrender/restriction of privileges for reasons where competence or conduct is not under investigation is also unreportable. App. D, 77sa, D79sa. Had Petitioner been administratively suspended, WRH could have immediately restored his credentials upon his being cleared, rather than preventing his return to practice based colorably upon the Providence investigation, a matter for which WRH was actually responsible (by asserting Petitioner's pedophilia).

The nidus for Petitioner's damages lies in WRH's retaliatory, unnecessary NPDB Report. HCQIA's § 11111(a) immunity bar shouldn't be implicated in scenarios such as this, one not demanding medical expertise. WRH's evocation of immunity creates a fact question about whether same was utilized to conceal its de facto retaliatory conduct and violation of state law in obtaining the confidential DSS file.[1]

This petition has implications for all physicians attempting to conform their conduct to avoid loss of clinical privileges and the disparagement of an NPDB entry, the latter making it impossible for them to join another hospital staff. Indeed, all of a physician's private conduct could have remote patient care implications. Here, the Fourth Circuit's affirmation of immunity stretches HCQIA's qualified provision of same into the realm of absolute immunity, whereby any amalgam of private conduct can be wrongfully utilized to evoke career-ending peer review. Such cannot be allowed.

Only statutory PRAs are eligible for § 11111(a) immunity...and "courts should first address whether the action [qualifies] before applying the § 11112(a) [immunity] factors...." *Gordon v. Lewistown Hospital*, 423 F.3d 184, 201 (3d Cir.2005). See also H.R. Rep. No. 99-903 at 21, reprinted 1986 U.S.C.C.A.N. at 6403. In *Gordon*,

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[1] See former S.C. Code § 20-7-690 (15) and (16), operable at time of alleged offense, no longer codified. *App. E*

Amicus Pennsylvania Medical Society suggested the nexus between conduct and adverse effect on patient welfare be judged by a standard of "concrete harm" or a realistic projection of it. *Id.* at 203, FN 13. Here, no concrete harm applied, the District Court never addressing whether qualification as a PRA occurred, granting summary judgment after incorrectly proceeding directly to § 11112(a) analysis. The Fourth Circuit erred in equating an unproven allegation to competence, failing to afford that term its plain language meaning in constructing HCQIA. App. A, 11a-14a.

While HCQIA doesn't define "competence," it clearly demarcates how matters of professional competence and conduct properly evoke the peer review mechanism while matters unrelated thereto expressly do not.[2] The statute doesn't address any relationship between "competence" and allegations occurring outside the professional context. It's indisputable that HCQIA, enacted to address medical malpractice and interstate movement of incompetent practitioners[3], doesn't contemplate penalizing a physician with an NPDB report in this situation. The NPDB tracks quality issues, not unproven administrative allegations.

The threshold rule of statutory construction is effectuation of plain language, the statute's text itself directing the Court's inquiry. *See Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 450, 122 S.Ct. 941,

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[2] 42 U.S.C. § 11151(9)(E)
[3] 42 U.S.C. § 11101

151 L.Ed.2d 908 (2002). "[I]n analyzing a statute's meaning, [the Court]...determine[s] whether the language at issue has a plain and unambiguous meaning." *Holland v. Big River Minerals Corp.*, 181 F.3d 597, 603 (4th Cir.1999) (internal quotes omitted). "Absent clearly expressed legislative intention to the contrary, that language must...be regarded as conclusive." *Consumer Product Safety Commission v. GTE Sylvania*, 447 U.S. 102, 108, 100 S.Ct. 2051, 2056, 64 L.Ed.2d 766(1980). HCQIA's legislative history demonstrates no consideration of situations such as this, rather it points entirely to matters of professional competence and/or conduct. See generally *H.R. Rep. 99-903, 1986 U.S.C.C.A.N. 6384*. Private conduct or allegations thereof is never addressed except by administrative suspension.

In holding Petitioner's suspension a PRA, the Fourth Circuit has expanded "competence" to include not only private conduct without ramifications upon a physician's abilities, but even unproven, later dismissed, allegations. This is not the plain meaning of "competence" in everyday usage and specifically not that contemplated in analysis of HCQIA's legislative history.

An NPDB adverse credentialing entry, a "scarlet A" in the world of clinical medicine, was not Congress' intent in such situations. Here, said entry ended Petitioner's ability to practice in hospitals, a must for surgeons, by necessity requiring operating rooms, anesthesia, and

recovery facilities, all unavailable in an office setting. Such a practitioner cannot be credentialed anywhere following such an NPDB entry.

Previously, the Fourth Circuit held HCQIA immunity "[was properly evoked when peer review was conducted reasonably], considering the totality of the circumstances, ...the statute not violating equal protection related to the legitimate government purpose of facilitating frank exchange of information among health care professionals conducting peer review." *Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 212 (2002). This case never required health care expertise, nor peer review.

"The reasonableness standard embodies discretion that... professionals have traditionally exercised in determining whether or not peers meet a requisite level of professional competence." *Id.* Here, professional competence was never reasonably implicated, the Fourth Circuit's rule in this matter far from definitive, failing to define specific conducts properly evoking a PRA. Said uncertainty has unqualified impact upon physicians whose alleged private conduct may now be subjected to peer review for matters unrelated to professional ability, potentially depriving them of a valuable property right. This Honorable Court should set the "metes and bounds" of what behaviors constitute a proper predicate for a PRA so physicians will have definitive guidance in conforming their conduct to avoid same.

Opining this PRA was based on Petitioner's "competence" to treat children, the Fourth Circuit cited a "nexus between the... suspension...and his [pediatric] practice...such that the hospital legitimately feared that... [Petitioner] might harm [children]." App. A, 19a-20a. Said holding, clearly particular to this case's facts, fails to cite such a nexus' particulars, leaving physicians unable to determine what might potentially deprive them of their right to practice. Hospitals may now be immunized for sanctioning physicians in virtually any scenario remotely implicating patient care. Such situations might rightfully evoke administrative suspension, but not punitive PRAs. In colorably providing the rudimentary procedural safeguards of § 11112(a), hospitals may now utilize HCQIA as a sword, not a shield, to silence whistleblowers. This was not Congress' intent, nor does it reconcile express consideration of administrative suspension in the statutory language itself. App. D, 75sa-79sa. The Fourth Circuit's holding must be reversed and this matter remanded for further deliberation on all claims.

II. The Fourth Circuit Wrongly Affirmed Summary Judgment to the Respondents Based Upon HCQIA's Qualified Immunity at 42 U.S.C. § 11111(a) and its Provisions to Qualify for Same at § 11112(a).

To overcome presumptive HCQIA immunity, § 11112(a)'s four-prong immunity test must be satisfied. A PRA must be taken:

> **(1) in the reasonable belief that the action was in the furtherance of quality health care,**
> **(2) after a reasonable effort to obtain the facts of the matter,**
> **(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and**
> **(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to *obtain facts and after meeting* the requirement of paragraph (3).**

"When evidence...arising from suspension of [a physician's] privileges raises a genuine issue of material fact as to whether the procedures afforded [him] were fair..., summary judgment...is precluded." *Islami v. Covenant Medical Center, Inc.*, 822 F.Supp. 1361 (N.D.Iowa 1992). Notwithstanding that this was never a proper PRA, factual questions remained that did not rightfully merit dismissal under HCQIA.

A. Petitioner's Privileges Were Suspended In the Absence of Any Reasonable Belief That Said Suspension Was in the Furtherance of Quality Healthcare. Allegations Are Not Fact.

Federal case law doesn't address whether unsupported allegations provide a reasonable belief that quality healthcare might be implicated. "The reasonableness requirements [necessary] for participants to be entitled to HCQIA immunity create an objective standard rather than a subjective good faith standard." *Austin v. McNamara*, 979 F.2d 728 (9th Cir. 1992). They mandate proof. Surely mere allegations, entirely unsupported, cannot objectively form a rightful basis for revocation of privileges, particularly when lesser sanctions reasonably protecting patients and Petitioner's right to practice were available. Here, the MEC, panel, and Board could not unanimously support WRH's recommendation to suspend Petitioner. A jury must be allowed to confront whether same was reasonable, bearing in mind Petitioner was never charged, never indicted, nor subjected to any Medical Board sanction.

While the Hospital could believe that the conduct alleged (if true) might impact quality healthcare, it cannot reasonably believe that unsubstantiated DSS allegations could do so. Psychiatric testing results failed to support pedophilia, two County DSS units determined said

allegations unfounded, his adopted daughter's physical examination demonstrated no evidence of sexual abuse, and letters of psychiatric professionals all attested to a lack of support for them; all were ignored. Such evidence doesn't support a reasonable belief that quality health care was threatened, rather it supports Petitioner's innocence and malice in Respondents' retaliatory quest to dismiss him from the staff.

B. Respondents Failed to Make A Reasonable Effort to Ascertain the Facts in the Matter; Rather They Recklessly Ignored the Evidence.

In *Brown v. Presbyterian Healthcare Services*, 101 F.3d 1324 (10th Cir. 1996), cert. denied 117 S.Ct. 1461, 520 U.S. 1181, 137 L.Ed.2d 564, a peer review was held unreasonably restrictive, not undertaken after reasonable effort to obtain the facts. There, the hospital and physicians were denied HCQIA immunity, their review unreasonably narrow, "[failing to] provide [a] reasonable basis for concluding [that a physician] posed a threat to patient safety." Instantly, where the plethora of evidence contrary to the DSS allegations was ignored in favor of the hearsay within hearsay testimony of a special needs child, the same applied. Such was not a reasonable attempt to obtain the facts when Petitioner's stakes were so high. Furthermore, there exists a fact question as to the Hospital

obtaining the confidential DSS investigative file in contravention of state law.[4] *See § E, infra.*

C. Respondents Failure to Provide Adequate Hearing Procedures Violated the Applicable Medical Staff Bylaws.

"Having three of respondent's accusers sit as his jury is a direct violation of respondent's right to a fair...hearing under the due process clause." *Zaman*, 285 S.C. 345 at 329. Instantly, this is what occurred, Respondents admitting that two panel members previously voted on Petitioner's suspension at the MEC level, the third not being present. "If [a] physician's allegations of a hospital's failure to provide him with fair hearing procedures [are] true, [the] hospital and [the defendant] physicians [will] not be entitled to [HCQIA immunity]." *Brader v. Allegheny General Hosp.*, 64 F.3d 869 (3rd Cir. 1995).

Here, proper indications for summary suspension under the Bylaws were ignored, Petitioner never informed that the majority of the committee had previously considered the matter until the hearing itself. Therein, summary suspension is deemed necessary when "in the best interest of patient care[5]," Petitioner, never an imminent threat to anyone, his outcomes and skills, unquestioned, and with no history of sexual boundary issues. Summary suspension allowed the

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[4] Formerly S.C. Code § 20-7-690(15) and (16), See § E, *infra*.
[5] Bylaws § Article VII, § 2

Hospital to halt his practice and income prior to his receiving any due process whatsoever, starting the clock for purposes of the thirty-day period wherein he could be restricted before mandatory notification to the NPDB. *HCQIA*, 42 U.S.C. § 11133(a)(1)(A). This again goes to WRH's intent to impugn Petitioner, maliciously destroying his career. Very simply, administrative suspension would have been non-punitive, encompassing no hearing and no NPDB report.

D. Respondents' Actions Against Petitioner Were Not Taken in the Reasonable Belief That They Were Warranted by the Facts.

Petitioner presented substantial evidence supporting his never sexually abusing his daughter. Likewise, lesser sanctions, respecting his property right in being able to practice and earn a living thereby, as well as patient safety, were readily available, yet ignored.

As allegations alone formed WRH's basis in acting against him, reasonableness demanded Petitioner either simply be assigned a chaperone, or voluntarily abate his limited pediatric practice during pendency of the DSS matter. These circumstances never warranted complete privilege revocation or reporting, Respondents' failure to consider these alternatives going to their actions' not reasonably being warranted under HCQIA. 42 U.S.C. § 11112(a)(4).

At a minimum, this presented a fact question for a jury which could reasonably conclude that ignoring exculpatory evidence, conducting a hearing before a panel of MEC members (the "indicting" body in this case, two of which had already voted on the matter), and finally resorting to the draconian sanction of summary suspension were fundamentally unreasonable actions. Rather it could readily conclude that facts supporting Petitioner were ignored, that as in *Zaman* fairness was precluded when those already involved reconsidered his sanction a second time, and that lesser sanctions or administrative suspension were appropriate. Finally, a jury could reasonably infer that retaliation was the impetus.

E. HCQIA Should Not Be Utilized As An Immunity Shield to Foster Violation of State Law By A Hospital.

Hales testified at deposition that he acquired statutorily protected DSS investigative information from the Clerk of Court in September 2004. App. A, 5a. Yet Hospital Counsel wrote DSS on October 8, 2004, requesting its confidential file claiming the Hospital was a "child care facility," an entity specifically excepted to receive such information (which was otherwise prohibited) under former S.C. Code §§ 20-7-690(15) and (16) (now no longer codified), Hales denying that WRH was such a facility. The Hospital therefore obtained said information, subsequently maliciously used it to attack Petitioner under false pretext, Hales

seemingly perjuring himself, as there is no explanation as to why counsel would have requested confidential DSS information if Hales already had it.

III. The Hospital is a State Actor under Applicable Law such that the Fourth Circuit Erred in Affirming the District Court's Dismissal of Petitioner's § 1983 Claim in lieu of Granting His Cross-Motion for Summary Judgment on Same.

"A physician's...[membership on] a hospital's staff is a property interest that may not be denied absent compliance with the Fourteenth Amendment's procedural and substantive due process requirements. " *Zaman*, 285 S.C. at 329. Now WRH, attempting to avoid Constitutional accountability in its defense, claims to be private, all evidence clearly demonstrating the contrary.

A. The Hospital Meets the Definition of a Public Hospital and State Actor Under Established Legal Precedent.

"Public hospitals are owned, sponsored, or managed by a governmental entity...a veteran's hospital, a state university hospital, or a local community hospital." *Van Campen v. Olean Gen. Hosp.*, 205 N.Y.S. 554, 555-56 (N.Y. App. Div. 1924), aff'd, 147 N.E. 219 (N.Y. 1925). [They] "are [state] instrumentalities, founded...in the public

interest, supported by public funds, and governed by managers deriving their authority from the state."[6] "A "private" hospital is...owned, maintained, and operated by a corporation or individual without any participation on the part of any governmental agency in its control." *Shulman v. Washington Hosp. Ctr*, 222 F. Supp. 59, 61 (D.D.C. 1963).

In *Edson v. Griffin Hospital*, 21 Conn.Sup. 55, 144 A.2d 341, 344 (Conn. Super. Ct. 1958), the test for a private hospital was formulated as, "whether, under the charter or corporate powers granted, [it has] the right to elect its own officers and directors, with the power to manage [its] own affairs." Here, WRH clearly meets multiple jurisdictional criteria to be public and a state actor, its legislatively-nominated Board ratified by the Governor.

South Carolina's Supreme Court has addressed the public versus private hospital question previously. *Burdge v. Greenville Hospital System*, 318 S.C. 312, 457 S.E.2d 610 (1995).

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[6] Id. at 555. Accord *Shulman*, 222 F. Supp. 59 at 61 (D.D.C. 1963) (public hospitals are supported by government funds and managed by same); *Edson*, 144 A.2d at 343 (Conn. Super. Ct. 1958) (city hospitals are public institutions); *Hughes v. Good Samaritan Hosp.*, 158 S.W.2d 159, 161 (Ky. 1942) (citing *Van Campen*..."public hospitals are publicly funded and operated"); *Levin v. Sinai Hosp., Inc.*, 46 A.2d 298, 300 (Md. 1946) (public corporations are funded and maintained by government).

There, [a hospital] was held public within § 1983's meaning where [it] "was created by [the] state in [the] public interest, supported by public funding..., and vacancies on [its] Board had to be approved by city council and/or county delegation [later} commissioned by the Governor." *Id.* at 315.

Comparing the *Burdge* criteria to those here instantly attributable to WRH, they are identical, far more than receipt of Hill-Burton funds, care of Medicare and Medicaid patients, and state reporting requirements held previously not to constitute state action. *Modaber v. Culpepper Mem. Hosp., Inc,* 674 F.2d 1023, 1026-27 (4th Cir.1982). Here, the Fourth Circuit's holding is in direct opposition to *Burdge.* Supported by public funding, WRH is a state actor, not electing its own officers or directors, its Board nominated by the County delegation and affirmed by the Governor. County representatives are ex-officio Board members, the County Attorney attending all Board Meetings. As an extension of the state, the Hospital is subject to Constitutional limitations, in particular due process and equal protection requirements, those very rights Petitioner was denied.[7]

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[7] See, e.g., *Yashon v. Hunt,* 825 F.2d 1016, 1022 (6th Cir. 1987) (procedural due process violations); *Sosa v. Bd. of Managers,* 437 F.2d 173, 174 (5th Cir. 1971) (14th Amendment violations); *Campbell v. St. Mary's Hosp.,* 252 N.W.2d 581, 585 (Minn. 1977) (...elementary that [14th Amendment] due process provisions...apply... if the actions to terminate plaintiff's...privileges done under color of state law."); *Ritter v. Bd. of Comm'rs,* 637 P.2d 940, 944-45 (Wash. 1981) (due process

Public hospitals cannot arbitrarily or unreasonably exclude physicians from practicing.[8] Conversely, actions of private hospitals are not subject to constitutional scrutiny.[9] Respondents' interest in WRH's being colorably "private" is readily apparent. To utilize unproven allegations to revoke Petitioner's privileges violates his Fourteenth Amendment protection against deprivation of life, liberty, or property without due process. "[T]he right to hold...employment and to follow a...profession free from unreasonable government interference comes within the 'liberty' and 'property' concepts of the...[Fourteenth]

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violations); cf. *Hayman v. City of Galveston*, 273 U.S. 414, 416-17 (1927) (public hospital limited by 14th Amendment); *Newton v. Bd. of Comm'rs*, 282 P. 1068, 1070 (Colo. 1929).

[8] See *Findlay v. Bd. of Supervisors*, 230 P.2d 526, 530 (Ariz. 1951) (hospital couldn't terminate privileges based on unconstitutional resolution); *Ware v. Benedikt*, 280 S.W.2d 234, 236 (Ark. 1955) (doctors may not be denied privileges based on unreasonable...rules); *Hamilton County Hosp. v. Andrews*, 84 N.E.2d 469, 471 (Ind. 1949) (physicians may not be discriminated against by county hospital); *Alpert v. Bd. of Governors*, 145 N.Y.S.2d 534, 537-39 (N.Y. App. Div. 1955) ("physicians may not be kept out of public hospitals by...unreasonable rules"); *Henderson v. City of Knoxville*, 9 S.W.2d 697, 698 (Tenn. 1928) (public hospitals may not enforce regulations violating state law); *Johnson v. City of Ripon*, 47 N.W.2d 328, 330 (Wis. 1951) ("public hospitals may not enforce unreasonable regulations pertaining to privileges").

[9] See, e.g., *Owens v. New Britain Gen. Hosp.*, 643 A.2d 233, 239 n.24 (Conn. 1994) (private hospital action not subject to Constitutional restraints); *Adkins v. Sarah Bush Lincoln Health Ctr.*, 544 N.E.2d 733, 739 (Ill. 1989) (private hospital not subject to due process considerations);

Amendment." *Greene v. McElroy*, 360 U.S. 474, 492, 79 S.Ct. 1400, 3 L.Ed.2d 1377 (1959).

B. The Hospital, as a Health Service District, Exists Only By Virtue of South Carolina State Law. It is Therefore a State Actor.

An Opinion Letter on file with the S.C. Department of Health and Human Services (SDHHS) from WRH attorney and Board member, Billy Jenkinson, describes WRH as "a hospital district organizing and existing under [state law]," further citing to "public authority documents" represented by [WRH]." Attached to Jenkinson's Opinion Letter is a County Council Resolution dated February 26, 2001, committing the county to provide twenty mills to WRH...annually over a period of three years providing $800,000.00 annually to repay loans. WRH now wrongfully asserts that it became "private" in 2002 when it was reincorporated.

The formation and operation of "Regional Health Services Districts" is governed by state law. S.C.Code § 44-7-2130 states:

> **[A] district constitutes an agency of the county to operate health care facilities and shall receive the proceeds from any special public hospital tax levied by the authorizing subdivisions.**

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> **The reincorporation under Article 16, Chapter 7, Title 44 of the 1976 Code of any public hospital corporation that heretofore has been designated as the agency of a county to operate and maintain public hospital facilities...in no way impairs or invalidates this designation...the reincorporated public hospital corporation shall continue as such just as if it had not been so reincorporated.**

County agency actions constitute state action and the cited case law supports WRH being a state actor. It cannot be allowed to argue otherwise, the Fourth Circuit erring in holding to the contrary. Despite reincorporation in 2002, federal case law also supports WRH being a state actor when analyzing it under 1) the nexus test, 2) the state compulsion test, and 3) the public function test from *Blum v. Yaretsky*, 457 U.S. 991, 1004, 102 S.Ct. 2777, 2786 (1982). State action becomes even more apparent based upon S.C. Code § 4-9-82 et seq., outlining requirements for acquisition of a hospital district, mandating that WRH assume the latter's obligations and responsibilities.

C. The Hospital's Attorney Admitted It Was a Public Hospital in 2004.

In an easily authenticated 2004 newspaper article, Jenkinson again affirmed that WRH is

public, citing to its public nature in its receipt of so-called Medicaid "disproportionate share" (DSH, pronounced "dish")) payments. WRH is a DSH hospital, said designation allowing it to receive cost reimbursement commensurate with its actual expenses in caring for Medicaid insureds, thereby reaping greater compensation than a private non-profit.

D. The Hospital's Board Chairman and Other Physicians Opined That It Was a Public and County Hospital

Harry Floyd, MD, WRH's prior Board Chairman, stated at deposition that it was "public"...a "county" hospital, affirming its Board composition, their nomination by the county delegation, and approval by the Governor. Floyd and two other physicians voted against Petitioner's summary suspension, all feeling that allegations alone, without proof, did not warrant such a drastic action. These physicians additionally pointed out the ill feelings, animosity, and friction between Petitioner, Juberg, and Hales, citing to the closeness of the votes at both the MEC and Board levels.

E. The Hospital For Purposes of The Medicaid Disproportionate Share Program Asserted It Was A Public Hospital, Receiving Cost Reconciliation From the SDHHS Commensurate Therewith.

Federal law requires Medicaid to consider "hospitals that serve a disproportionate number of low-income patients with special needs" when determining payment rates for care.[10] Its status as a statutorily created hospital district allowed WRH to receive reimbursement via intergovernmental transfer (IGT) from the state and federal governments to achieve cost parity for its Medicaid expenses.

Petitioner's Fourth Circuit Appendix showed IGT payment transfer forms and a copy of the State Plan under Title XIX of the Social Security Act. In the latter, the Hospital is designated expressly as a "small rural public hospital," notably continuing said IGT requests after it was supposedly private.

IGTs involve fund transfer between governmental entities and only state-owned or operated "units" can execute an IGT. In the case of Medicaid, a "unit" transfers funds to the state Medicaid agency which then draws down the federal match paid to a publicly-owned hospital. The federal government's match is based on the state's matching rate. *From National Conference of State Legislatures at http://www.ncsl.org/programs/health/forum/cot/strat3.htm.*

WRH cannot reconcile how all its IGT authorizations acknowledging public status are signed by WRH's Judy Gamble or Hales, yet the

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[10] 42 U.S.C.A. §§ 1396a(a)(13)(A)(iv), 1396r-4

latter testified at deposition that it was private. Hales clearly knew WRH was still viewed as a hospital district; *a fortiori*, in a letter to SDHHS after it claimed to be ostensibly private, he expressly cited to its public ownership, forwarding the previously provided 2001 Opinion Letter and County Resolution. When it comes to revenue, WRH insists on being a hospital district created and doing business under state law; yet when faced with respecting Petitioner's fundamental Constitutional rights, it conveniently insists it is private. The Fourth Circuit failed to reconcile this disparity.

The Title XIX plan describes how public hospitals receive DSH retrospective cost settlements calculated in accordance with 100% cost methodology while non-public hospitals receive retrospective cost settlements limited to 90% of Medicaid cost. WRH, receiving 100% reconciliation, is a public hospital for purposes of DSH, recognized as such by the State, and thereby eligible for IGTs. The Fourth Circuit failed to acknowledge how each and every facet of its organization and operation attests to WRH being a state actor. It should not be allowed to escape liability for the constitutional wrong it has heaped upon Petitioner.

F. Fundamental Principles of Equitable Estoppel Should Prevent The Hospital from Choosing When to be Public Versus Private.

Equitable estoppel under South Carolina law is the inhibition to assert a right by reason of mischief following one's own fault and may arise without intention on the part of the party estopped to relinquish or change any existing right. Prejudice to the other party is essential. *Janasik v. Fairway Oaks Villas Horizontal Property Regime*, 307 S.C. 339, 339, 415 S.E.2d 384 (1992). It arises from "conduct and prevents assertion of...rights contrary to equity and good conscience." *Smith v. Williams*, 141 S.C. 265, 139 S.E. 625 (1927). The state may be subjected to the estoppel doctrine. *See, e.g., Townes Assocs. Ltd. v. City of Greenville*, 266 S.C. 81, 87, 221 S.E.2d 773, 776 (1976).

Here, WRH asserted that it was a state actor in maximizing cost settlements from the Federal Treasury, asserting that it was private for purposes of avoiding § 1983 liability. As prejudice to Petitioner is obvious, equity and good conscience should prevent these mutually exclusive alternatives. The evidence supports WRH being a state actor and estoppel principles should have prevented it being held private.

G. The Hospital Denied Petitioner Fundamental Due Process and Equal Protection Rights Under The Fourteenth Amendment. It Knew of These Well-Recognized Constitutional Rights and Should Have Been Held Accountable.

"The overall concept of due process...is a flexible one;...the type of procedural protections required in a particular situation depends largely upon the circumstances." *Morrissey v. Brewer,* 408 U.S. 471, 481, 92 S.Ct. 2593, 2600, 33 L.Ed.2d 484 (1972). In determining when a particular procedure is required, three factors should be considered:

> **First, the private interest...affected by the official action; second, the risk of an erroneous deprivation...through the procedures used, and the probable value, if any, of additional... procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the...substitute procedural requirement would entail. *Mathews v. Eldridge,* 424 U.S. 319 at 335, 96 S.Ct. at 903 (1976).**

Here, Petitioner had notable interests in his practice, his sole source of income, there being substantial risk of erroneous deprivation given the negative emotions attached to alleged sexual exploitation of children, local publicity, and his disdain by WRH. Clearly, a governmental entity with an interest in patient safety should have utilized administrative suspension in lieu of peer review.

The Eighth Circuit in *Klinge v. Lutheran Charities Association of St. Louis*, 523 F.2d 56 (8th Cir.1975), held that:

> **The...Fourteenth Amendment prohibits depriving any person of property without due process of law. There is no dispute that in a public hospital the provisions of the Fourteenth Amendment must be met...**

Here, WRH failed miserably, breaching its duty, as this Honorable Court will recognize. Petitioner, the target and victim of its disdain, should now be made whole.

IV. Petitioner's State Law Claims Do Not Necessarily Fail on the Merits.

As an alternative basis for affirming the District Court, the Fourth Circuit opined that Petitioner's State Law claims fail on the merits. Petitioner asserts that such is not the case.

Initially, as to his Intentional Infliction of Emotional Distress (IIED) claim, Petitioner meets his evidentiary burden in proving Respondents' conduct outrageous. Abusive peer review, breach of its Bylaws, a sham hearing, and denial of basic HCQIA and Constitutional rights clearly amounts to egregious behavior, particularly when WRH knowingly denied it was a state actor, not to

mention fact issues existing as to whether Petitioner's summary suspension was retaliatory.

Respondents cited *Folkens v. Hunt*, 290 S.C. 194, 348 S.E.2d 839, 845 (Ct. App. 1986) proposing that not all business-related conduct causing emotional distress serves as a basis for an outrage claim. Nonetheless, *Folkens* stated that, "conduct growing out of a business relationship may be so outrageous and shocking as to be actionable." *Id at 845.* Here, Respondents' conduct viewed in a light favorable to Petitioner could reasonably be inferred to be, "so 'extreme and outrageous' as to exceed 'all possible bounds of decency'...intolerable in a civilized community.'" *Ford v. Hutson*, 276 S.C. at 162, 276 S.E.2d at 778 (1981). *Folkens* went on to state that the Defendants' actions there:

> **[D]id not involve excessive self-help in...or avoiding a legal obligation that arose out of their...legal relationship, one of three factors often present where liability for [outrage] has been found. *Todd v. S.C. Farm Bureau Mutual Insurance Co.*, 283 S.C. 155, 169, 321 S.E.2d 602 at 610-11 (Ct.App.1984);**

Here, Respondents did act akin to self-help in avoiding a legal obligation to provide Petitioner due process as demanded by §§ 1983 and 11112(a), their conduct additionally compatible with the two other factors wherein IIED liability has been found:

> **First, a pre-existing legal relationship between the parties...; Second,...defendant's conduct involved excessive self-help in asserting a legal right or avoiding a legal obligation..., or [was] coercive and oppressive...; Third, [that] the defendant calculatedly inflicted suffering...contemptuously disregard[ing] the plaintiff's present emotional suffering...to punish [him] for prior failure to comply. *Intentional Infliction of Emotional Distress by Outrageous Conduct*, 82 Colum.L.Rev. 42. 63-64 (1982). *From* Todd, 283 S.C. at 169.**

The Restatement Second provides that:

> **[A]busive conduct by a defendant in actual or apparent authority over a plaintiff, or with power to affect the plaintiff's interest, may give rise to a characterization of the conduct as outrageous. *Second Restatement of Torts*, Section 46 (Supp.1948).**

Here, WRH had actual authority over and a preexisting contractual relationship with Petitioner. These Respondents' abusive treatment was clearly oppressive, particularly since less draconian alternatives were available, yet ignored. His relationship to WRH was in many ways akin to

employment, yet he is afforded no legal whistleblower protection. Material fact questions should preclude summary judgment on this claim.

Secondly, as to Petitioner's claims for tortious interference with his existing and prospective contracts with WRH, patients, and managed care plans, Respondents knew of these, procuring their breach through his unconstitutional suspension. His implied contractual relationship with WRH through the Bylaws exchanged certain rights for duties, Petitioner accepting call, unassigned patients, and completing medical records in exchange for due process rights relevant to his privileges. Through abusive peer review, Respondents denied him the latter, resulting in inability to fulfill his contractual obligations to all of the above. He now cannot perform surgery there or elsewhere, cannot be licensed in other states, and has been forced to essentially cease medical practice, all based solely upon unproven allegations, subsequently dismissed.

The crux of Petitioner's ongoing damages lies in his defamation claim, providing probative examples of Respondents' abuse of the peer review process and the malice with which they acted against him. Had WRH utilized administrative suspension or a lesser sanction, Petitioner would not have been defamed, no NPDB report being necessary.

Respondents wrongfully asserted that Petitioner proposes that conduct and not allegations are subject to HCQIA. Actually, HCQIA's implementing regulations are relevant to the extent that administrative suspension based upon allegations might have been a reasonable alternative here (*45 C.F.R. 60.3*), but implementation of the peer review process was not only unnecessary and patently wrong, it demonstrated malice on their part.

> **Privileged communications... are absolute, conditional or qualified, and when communication is absolutely privileged no action will lie for its publication, regardless of circumstances under which it was published, and when qualified, plaintiff may recover if he shows that it was actuated by malice. *Johnson v. Independent Life & Accident Ins. Co.*, 94 F.Supp 959 (D.S.C. 1951).**

Here, WRH's defamatory NPDB entry was not necessary and truly without explanation, other than it being maliciously retributive for Petitioner's zealous patient advocacy, the Nursing Director's sanction, and his conflicts with Hales and Juberg.

NPDB entries are not absolutely privileged. *Anbar v. Leahan*, 1998 WL 314691 (E.D.Pa.1998)

(unpublished), is instructive, not only as to the issue of privilege, but directly to the issue of the defamatory character of an NPDB entry. HCQIA confers immunity on "any person who makes a report to the NPDB, "without knowledge of...falsity...in the report." 42 U.S.C. § 11137(c). Immunity exists unless there is sufficient evidence for a jury to conclude the report was false and the reporting party knew so. *Brown*, 101 F.3d 1324 at 1334. Thus, what the statute actually confers is a qualified, not absolute privilege.

The *Anbar* court held that whether Defendant claims personnel falsely reported a settlement paid on behalf of a physician actually had knowledge of its falsity was a jury question. "The very fact that he was required to explain the NPDB report supports his suffering impairment of reputation, standing in the community or personal humiliation." *Anbar*, 1998 WL 314691 at 6. The Tenth Circuit, confronted with the same situation, held that this type of evidence mandated jury deliberation. *See Brown*, 101 F.3d at 1336.

WRH knew it wrongfully entered an NPDB report attributable to Petitioner, conveying its initial report under the moniker of "sexual misconduct" when all truly at issue were mere allegations. It knew that this was false, failing to make that distinction. These undisputed facts and the circumstances under which the NPDB Report was entered as in *Anbar*, present a jury question as to WRH's knowledge of its falsity and malice in

entering the unnecessary report. Therefore, the Defendants were never entitled to summary judgment on Petitioner's defamation claim.

As to Petitioner's Breach of Contract and Promissory Estoppel claims, the Fourth Circuit cites to a lack of state law holding the Bylaws contractual, an assertion not necessarily defeating his claim for breach, as there is likewise no holding that such Bylaws are not contractual. WRH made his privileges subject to and governed by its Bylaws and had a corresponding obligation implied by law to abide by them in attempting to suspend or revoke them. Moreover, the Bylaws unequivocally represent an implied contract. "Rules used to interpret statutes, contracts, and other written instruments are applicable when construing corporate bylaws." William M. Fletcher, *Fletcher Cyclopedia of the Law of Private Corporations* § 4195 (perm. ed. rev. vol. 1992).

To recover for a breach of contract Petitioner must prove a binding contract entered into by the parties. Presently, there is a split of authority in states which have considered the contractual nature of Bylaws; however, most jurisdictions hold them contractual. The nearby North Carolina Appellate Courts have interpreted Bylaws as contractual in the absence of contrary precedent:

> **Hospital bylaws governing suspension and termination of ... privileges were part of physician's contract with hospital, although**

> **hospital was required by statute to have such bylaws and physician was required by statute to comply with them; physician agreed to be bound by terms of bylaws when he applied for staff privileges, and pursuant to that agreement, physician became member of medical staff and treated patients at hospital... If hospital's offer to extend...privileges to physician includes condition that [he be bound by them] and physician accepts offer, those bylaws become part of contract, as there is mutual assent to be bound...** ***Virmani v. Presbyterian Health Services*****, 127 N.C. App. 71, 488 S.E.2d 284, 287-288 (1997).**

Secondly, Petitioner must show breach or unjustifiable failure to perform the contract. Article VIII, § 4(a) of the WRH Bylaws states explicitly:

> **No staff member who has actively participated in the consideration of the adverse recommendation shall be appointed a member of this Hearing Committee...**

WRH could have utilized non-staff physicians, members who had not participated on

the MEC, or arbitrated Petitioner's suspension, as contemplated by HCQIA at § 11112(b)(3), yet here, despite express exclusion in the Bylaws, it maliciously elected to seat a panel consisting of at least two physicians who had already participated.

Thirdly, damages must result as a direct and proximate result of the breach. *Fuller v. Eastern Fire & Casualty Insurance Co.*, 240 S.C.75, 124 S.E.2d 602, 610 (1962). Had the Bylaws been followed, Petitioner would have received a fair hearing before an unbiased, disinterested panel which would have recognized the peer review injustice. He would still be practicing today, unfettered and successful.

South Carolina's elements for contractual breach are virtually identical to those of Virginia, another state whose case law doesn't explicitly recognize Bylaws as contractual. *Westminster Investing Corp. v. Lamps Unlimited, Inc.*, 379 S.E.2d 316, 317 (Va.1989). Nonetheless, the Fourth Circuit itself, in an unpublished opinion concerning peer review and applying Virginia law, *Wuchenich v. Shenandoah Memorial Hospital*, 215 F.3d 1324 (4th Cir. 2000), held that [Plaintiff]:

> **[S]tated a breach of contract claim with respect to [the] Bylaws.... we hold...that [hospital] owed...the legal obligation to follow its bylaws, breach[ing] that obligation,**

and [Plaintiff] suffered damages as a result.

Here, the Fourth Circuit's opinion is clearly at odds with its own prior ruling. WRH violated Bylaws Article VII, § 2, where it was empowered to summarily suspend only, "whenever action must be taken immediately in the best interest of patient care... " Here, such wasn't implicated, as even if the allegations against Petitioner were proven, he was never an imminent threat, particularly to adult patients, which encompassed the overwhelming majority of his practice.

Additionally, Respondents argued Petitioner's breach of contract claim should be dismissed because the Bylaws provide immunity from this claim. Said provision only applies to good faith actions (which this clearly was not). Thus, Respondents are not entitled to immunity under the Bylaws (or HCQIA). Said argument was made in *Virmani*, 127 N.C. App. 71, 488 S.E.2d 284 at 289, rejected there, and likewise should be rejected here.

The Fourth Circuit next turns to Petitioner's S.C. Unfair Trade Practices (UTPA) claim.[11]. Respondents engaged in unfair and deceptive practices inflicting damages upon him, said practices having substantial impact upon the public's interest, clearly capable of repetition, and potentially driving physicians from the community,

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[11] S.C. Code § 39-5-20

further depriving its already-underserved population of care.

The UTPA should be construed broadly to decrease the burden of proving liability, not narrowly as the Fourth Circuit suggests. Its purpose is to give, "additional protection to victims..., not to make a case harder to prove...." *DeBondt v. Carlton Motorcars, Inc.*, 342 S.C. 254, 269, 536 S.E.2d 399, 407 (Ct. App. 2000).

While medical practice isn't expressly encompassed in the UTPA's "trade and commerce" elements, the statute does include, "the advertising, offering for sale, sale or distribution of any services." Read broadly as the relevant case law supports, the provision of hospital-based surgery clearly is "distribution of services." *Baker v. Chavis*, 306 S.C. 203, 410 S.E.2d 600, 603 (Ct. App. 1991) held that:

> **[The] Definition of "trade" and "commerce" set forth in [UTPA], as "including" the sale or distribution of any services and any property, tangible or intangible, is not intended to be exclusive.**
>
> ***
>
> **The statute's... "shall include" clearly suggests the legislature did not intend to limit "trade" and "commerce" to only the listed transactions...**

Petitioner's elimination has an impact on WRH's service area, his exclusion amounting to a fifty percent decrease in surgical staff, his associate thereafter a becoming a Hospital employee. Antitrust injury is not an element of the UTPA, but certainly lack of any alternative other than a Hospital-owned practice creates a potential for horizontal price control. To assert that Petitioner's summary suspension was taken to protect patients ignores his unyielding quest to improve patient care there, not to mention that patient safety could have been preserved using administrative suspension.

Petitioner presented evidence sufficient for a reasonable jury to find that he was a retaliated against for addressing deadly medication errors and unidentified tissue found at WRH. Said reasonable inference underscores the reprehensibility and unfairness inherent instantly, as quality should be at the forefront, not improperly eliminating physicians opposing administrative malfeasance. WRH never identified the tissue from the Operating Room and its "external" review of one of the medication deaths was performed by Greeley and Company, founded by Hugh Greeley, one of the WRH's expert witnesses offering testimony against Petitioner.

"Repeatable unfair acts...in the conduct of trade or commerce have sufficient impact upon public interest to be actionable under the [UTPA]." *Noack Enterprises, Inc. v. Country Corner, 290 S.C.*

475, 351 S.E.2d 347, 350 (Ct. App. 1986). Good faith peer review, a necessary quality improvement component, is privileged, undiscoverable by statute[12], and therefore not subjected to public scrutiny. Here, it was practiced unethically, violating the Bylaws and HCQIA, WRH retaliating when its Nursing Director filed a quickly dismissed Medical Board Complaint against Petitioner related to matters resolved years earlier. Peer review was an obvious retaliatory choice for WRH, allowing it to expel Petitioner with virtual impunity. Such deceptive practices have sufficient impact upon the public interest to be actionable under the UTPA, potentially allowing trebling of damages. S.C. Code § 39-5-140.

Lastly, as to the elements of Petitioner's civil conspiracy claim, it is clear that proof of same can require inference and be circumstantial. While, "clandestine activity is not an element...many conspiracies are furtively formed, thereby making proof...difficult for a plaintiff." Consequently, civil conspiracy has been characterized as, "...covert, clandestine...not susceptible of proof by direct evidence." *Kuznik v. Bees Ferry Associates,* 342 S.C. 579, 610, 538 S.E. 2d 15, 31 (Ct. App. 2000).

Instantly, the circumstantially-supported conspiratorial facts alleged carry no less credibility than were they based on direct evidence, creating a jury question. The Fourth Circuit termed this claim "speculation," despite Juberg and Hales'

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[12] S.C. Code §§ 40-71-10, 30-71-20

independent interests, financial and otherwise, their acts constituting reckless, unwarranted evocation of the peer review process outside their scope of agency. App. A, 26a-27a. Intra-corporate immunity doctrine is inapplicable. Their individual disdain for Petitioner, opposing Hales' administrative policy and the Juberg's staff membership[13] led Respondents to subvert the peer review process based upon personal animus, not legitimate quality concerns.

Increasing Hospital income, in lieu of spending on patient safety, inures to Hales' benefit, going to his administrative competence. Juberg required privileges to generate income and opposition to his staff membership endangered that potential. These independent stakes, personal and financial, in Petitioner's exclusion played the dominant role in ending his career for no reason. Such would not have occurred had Respondents properly evoked administrative suspension or taken less draconian action than suspension of all of his privileges.

Kuznik goes on to address punitive damages in civil conspiracy claims requiring proof of "willful, wanton [conduct] or [same] undertaken in reckless disregard of plaintiff's rights." *See McGee v. Bruce Hosp. Sys.*, 321 S.C. 340, 468 S.E.2d 633 (1996). "Willfulness" has been defined as a conscious

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[13] Juberg, previously sanctioned by North Carolina and Ohio's Medical Boards based on sexual issues involving a patient, was admitted to WRH's medical staff over Petitioner's objection.

failure to exercise due care. *Hawkins v. Pathology Assocs. of Greenville, P.A.*, 330 S.C. 92, 498 S.E.2d 395 (Ct. App. 1998). *Kuznik at 611*. Recalling that administrative suspension was immediately available, the actions of these co-conspirators meets this standard, the same precluding any limitation upon liability or punitive damages under *S.C. Code Ann. § 33-56-180(a)* based on the Hospital's alleged 501(c)(3) status.

Hales and Juberg had a personal economic stake in acquisition of Petitioner's patient base independent of the other Respondents, conforming to the *Greenville Pub. Co. v. Daily Reflector, Inc, 496 F.2d 391, 399 (4th Cir. 1974)* exception to *Oksanen v. Page Memorial Hosp.*, 945 F.2d 696 (4th Cir.1991) and its progeny.

> **The more important aspect of *Greenville* for ... purposes of peer review is the degree of control the officer or agent with the independent interest exercised over...defendant's decision-making process. If the officer cannot cause a restraint to be imposed and his firm would have taken the action anyway, then any independent interest is largely irrelevant... *Id.* at 705.**

Here, Hales and Juberg wrongfully initiated this peer review in lieu of administrative

suspension. At their sole discretion, they promoted said wrongful action to the MEC, which failed to recognize that administrative suspension or monitored practice was the proper alternative.

Todd v. S.C. Farm Bureau Mut. Ins. Co., 276 S.C. 284, 278 S.E.2d 607, 611 (1981), held that civil conspiracy cannot arise from the same facts alleged to support other causes of action. Here, the Hales-Juberg conspiracy, both with independent stakes and indispensable roles in the peer review action, constitutes an independent conspiracy separate from that of the other Respondents. As such, their wrongful evocation of peer review constitutes a valid civil conspiracy claim. At a minimum, material issues of fact are obvious such that a reasonable jury could conclude that Juberg and Hales maliciously acted against Petitioner under the *Greenville* exception to *Oksanen*.

CONCLUSION

Based upon the above, this petition for a writ of certiorari should be granted.

Respectfully Submitted,

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Counsel for Petitioners

APPENDIX

UNITED STATES COURT OF APPEALS
For The Fourth Circuit

Blake H. MOORE, MD, FACS, Individually and as the Personal Representative of the Estate of Angela Lynn Moore; Kingstree Surgical Associates, LLC,

Plaintiffs-Appellants,

v.

WILLIAMSBURG REGIONAL HOSPITAL; John Hales; Breton Juberg, MD; Evelyn Ansa, MD; Joel Bonaparte, MD; Bernadette Bonaparte, MD; Kenneth Johnson, MD; Steve Corey, DPM; Michelle Corey-Butterworth, DPM; Kevin Springle, MD; Gilbertas Rimkus, MD, Jointly and Severally,

Defendants-Appellees,

And

Raymond Allen, MD; Bashir Obeidou, MD; Marion Riggs, Jointly and Severally,

Defendants,

Providence Hospital,

Party in Interest.

No. 07-1966.

Appeal from the United States District Court
For the District of South Carolina, at Florence.
Terry L. Wooten, District Judge.
(4:05-cv-02940-TLW)

Argued: Dec. 3, 2008.

Decided: March 12, 2009.

Before WILKINSON, DUNCAN, and AGEE,
Circuit Judges.

Affirmed by published opinion. Judge Wilkinson wrote the opinion, in which Judge Duncan and Judge Agee joined.

COUNSEL

ARGUED: Charles William Hinnant, Jr., Medicolegal Consultants, L.L.C., Anderson, South Carolina, for Appellants. Travis Dayhuff, Nelson, Mullins, Riley & Scarborough, L.L.P., Columbia, South Carolina, for Appellees. **ON BRIEF:** Stuart M. Andrews, Jr., Nelson, Mullins, Riley & Scarborough, L.L.P., Columbia, South Carolina, for Appellees Williamsburg Regional Hospital and John Hales; Marian Williams Scalise, Lydia L. Magee, Richardson, Plowden & Robinson, Myrtle Beach, South Carolina, for Appellees Breton Juberg, MD, Evelyn Ansa, MD, Joel Bonaparte,

MD, Bernadette Bonaparte, MD, Kenneth Johnson, MD, Steve Corey, DPM, Michelle Corey-Butterworth, DPM, Kevin Springle, MD, and Gilbertas Rimkus, MD.

OPINION

WILKINSON, Circuit Judge:

In this case, a physician brings multiple state law and federal due process claims against a hospital and its officials for suspending his staff privileges based on allegations that he had sexually abused his adopted daughter. While the scope of immunity under the Health Care Quality Improvement Act, 42 U.S.C. § 11101 *et seq.*, certainly has limits, we think the immunity attaches to defendants under the circumstances here, and plaintiff's state law claims fail in any event. We also reject plaintiff's claims that the hospital's suspension of his privileges violates the Due Process Clause, both because the decision to suspend plaintiff's privileges was not state action and because the procedures afforded plaintiff satisfied the Fourteenth Amendment. For these reasons, we affirm the district court's grant of summary judgment to defendants.

I.

Plaintiff is a general surgeon who treats both children and adults in the course of his practice. He formerly held privileges at Williamsburg Regional Hospital ("WRH") in Kingstree, South

Carolina. WRH serves a population of fewer than 40,000 people and was previously the Williamsburg County Memorial Hospital. Since October 2001, it has operated as a private non-profit corporation, but the state continues to be involved: the Governor approves the Board of Directors and the state and county provide funding. While practicing at WRH, plaintiff raised numerous complaints about patient care at the hospital, including fatal mistakes in medication dosages and the mishandling of human tissue specimens. He alleges that WRH officers threatened him for voicing these complaints and took the following actions in retaliation.

At some point after the alleged threats, South Carolina Department of Social Services ("DSS") took plaintiff's three adopted children into emergency protective custody because of allegations that plaintiff's wife had physically abused the children. DSS filed a complaint against plaintiff and his wife in Family Court and placed the children in foster care. While in foster care, plaintiff's adopted daughter told her therapist that she had been sexually abused by plaintiff and his wife. In 2003, two DSS units each investigated the sexual abuse allegations, but found the evidence to be inconclusive and declined to investigate further. Then, in 2004, Clarendon County DSS conducted a third investigation and, after finding by a preponderance of evidence that plaintiff and his wife had sexually abused the child, filed a Family Court complaint seeking to terminate plaintiff's and his wife's parental rights and place them on

the Central Registry of Child Abuse and Neglect.

Soon after DSS filed the complaint, defendant Dr. Breton C. Juberg, the WRH Chief of Staff and Chairman of the Medical Executive Committee ("MEC"), became aware of the DSS sexual abuse allegations against plaintiff. He informed defendant John C. Hales, Jr., the Chief Executive Officer of WRH, of the allegations, and Hales obtained a copy of the complaint and other documents from the clerk of the Family Court. The complaint detailed statements the child made to her DSS caseworker, therapist, foster parents, and forensic interviewer about the sexual abuse, and also recounted the prior physical abuse case that had resulted in a finding of Abuse and Neglect against plaintiff and his wife. After reviewing these documents, Hales and Juberg agreed to summarily suspend plaintiff's hospital privileges until the DSS sexual abuse allegations were resolved.

In a letter dated September 13, 2004, Juberg notified plaintiff that his privileges were summarily suspended pursuant to the hospital's Medical Staff Bylaws provisions for corrective action. Juberg explained that "[b]ased upon serious allegations of sexual misconduct of a minor child ... the Medical Staff and [WRH] believe that the best interest of patient care and welfare is served by an immediate summary suspension of your clinical staff privileges." Juberg also notified plaintiff that the MEC would review his summary suspension that evening and invited him to

present his case, although he would not be allowed to vote on the matter.

At the meeting, the MEC considered several documents from plaintiff's DSS file including the sexual abuse complaint, the DSS probable cause finding, the child's forensic interview report, progress notes from her therapy sessions, drawings by the child, and a Family Court order which included information about the prior physical abuse case. Plaintiff attended the meeting and presented argument, but the MEC ultimately voted to continue his suspension.

Two days later, Hales sent a letter to plaintiff confirming that the MEC had voted to continue his suspension and informing plaintiff of his right to have the decision reviewed in a hearing with representation by counsel pursuant to Article VIII of the hospital's bylaws. The next day, WRH submitted a report to the National Practitioner Data Bank ("NPDB"), as it believed was required by 42 U.S.C. § 11133,[1] stating that plaintiff's clinical privileges had been summarily suspended

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1. "Each health care entity which-(A) takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days ... shall report to the Board of Medical Examiners." 42 U.S.C. § 11133. However, as the NPDB Guidebook emphasizes, a suspension is not reportable when it is due to "administrative reasons not related to professional competence or professional conduct." *See* NPDB Guidebook, at E-21 (September 2001).

indefinitely because of "serious allegations of sexual misconduct of a minor child."

Plaintiff requested a review hearing which was held on November 22, 2004. Prior to the hearing, WRH provided plaintiff a list of witnesses expected to testify and a list of Hearing Panel members who were not his economic competitors. To accommodate plaintiff's objection, WRH removed one doctor from the panel who had previously treated plaintiff's children. Plaintiff's counsel was then notified of the final panel composition by letter and given an opportunity to object, but plaintiff did not object before the hearing.

At the hearing, Juberg and plaintiff's counsel presented argument. Both sides called witnesses, cross-examined witnesses, and presented documents for the panel to consider. Plaintiff and his wife testified that they did not sexually abuse their daughter and presented evidence including the result of a neuropsychiatric test indicating that plaintiff failed to meet the diagnostic criteria for pedophilia, a prior DSS notice that a sexual abuse investigation was unfounded, and a forensic examination that did not prove sexual abuse. But, during the two additional months the hearing was held open, plaintiff was not able to come forward with evidence the panel considered adequate to dispel its concerns. Ultimately, the panel issued a report upholding the MEC's decision to continue plaintiff's summary suspension.

Plaintiff appealed the panel's decision to WRH's Board of Directors at a full-blown hearing on April 11, 2005. A week later, after receiving additional evidence, the four board members present voted unanimously to uphold the suspension. This marked the end of the review process.

A few months later, on July 7, 2005, DSS filed a motion for voluntary nonsuit with prejudice in the sexual abuse case against plaintiff on the grounds that it would not be in the child's best interests to continue the case. DSS argued that it would be traumatic for the child to testify and the suit would not benefit the child because plaintiff's parental rights had already been terminated pursuant to an agreement of the parties in the physical abuse case. The Family Court entered an order granting DSS's motion for nonsuit on July 11, 2005.

A month later, plaintiff sent a letter to WRH requesting that his clinical privileges be immediately reinstated because DSS had dismissed the sexual abuse suit and no one had ever filed criminal charges against him. WRH did not reinstate plaintiff, however, because he would not authorize the hospital where he had been practicing during his suspension to provide the necessary credentialing information that WRH needed to reinstate him in accordance with the bylaws. Plaintiff had also requested that WRH void its NPDB report and asserts that he has not been able to accept employment with other health care providers because of the report.

On October 14, 2005, plaintiff filed this suit. He claims that WRH, Hales, Juberg, and other WRH staff members are liable in damages because WRH's suspension of his privileges violated various state laws and 42 U.S.C. § 1983. After discovery, defendants filed a motion for summary judgment on all claims and plaintiff filed a cross-motion for summary judgment on his § 1983 claims. The district court granted defendants' motion on all counts. The court held that defendants were entitled to immunity from plaintiff's state law claims under the Health Care Quality Improvement Act, 42 U.S.C. § 11101 *et seq.*, and that plaintiff's § 1983 claims failed on the merits and because WRH was not a state actor. Plaintiff appeals, and we review the district court's grant of summary judgment *de novo*. *See Holland v. Washington Homes, Inc.*, 487 F.3d 208, 213 (4th Cir.2007).

II.

Plaintiff alleges that defendants are liable for intentional infliction of emotional distress, tortious interference with existing and prospective contractual relationships, defamation, breach of contract, promissory estoppel, unfair trade practices, and civil conspiracy. The district court held that defendants were entitled to immunity from all these state law damages claims pursuant to the Health Care Quality Improvement Act ("HCQIA"), 42 U.S.C. § 11101 *et seq.*

A.

The HCQIA provides immunity from damages to participants in a "professional review action" if the action meets certain standards and follows certain procedures. 42 U.S.C. § 11111(a)(1). HCQIA provides this immunity as "incentive and protection for physicians engaging in effective professional peer review." *Id.* at § 11101(5). Congress believed that effective peer review, including mandatory reporting to a nationwide database, could alleviate the national problem of "[t]he increasing occurrence of medical malpractice" by "restrict[ing] the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance." *Id.* at § 11101; *see also Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 211-12 (4th Cir.2002) (discussing the purpose of HCQIA). However, HCQIA does not provide unqualified immunity to all peer review decisions. In order to ensure that such review is effective and not abused, HCQIA only provides immunity to "professional review actions" based on a physician's "competence or professional conduct," 42 U.S.C. § 11151(9), and it mandates specific standards and procedures that must be followed, *id.* at § 11112(a).

The issue here is whether WRH's action constitutes a "professional review action" within the meaning of HCQIA and therefore falls

within the scope of HCQIA immunity at all.[2] Plaintiff argues that WRH's suspension of his privileges is not a "professional review action" because it was not based on his "competence or professional conduct." He argues that allegations of sexual abuse outside of the professional context are not related to his competence or his professional conduct as a doctor. He urges a stark dividing line between private and professional conduct and contends that "[n]on-medical allegations" cannot be the basis for professional review actions because they are only proper when medical expertise is necessary to the determination.

Even though many "professional review actions" are based on (1) medical conduct at a health care

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[2] Section 11151(9) of HCQIA defines "professional review action" as "an action or recommendation of a professional review body ... which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges ... of the physician." 42 U.S.C. § 11151(9). It provides further that "an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on-" (A) a physician's association with a professional society, (B) a physician's fees or advertising, (C) a physician's participation in certain types of health plans, (D) a physician's association with a private group practice, "or (E) any other matter that does not relate to the competence or professional conduct of a physician." *Id.*

facility that (2) occurred at some point in the past, *see e.g., Gabaldoni v. Washington County Hosp. Ass'n,* 250 F.3d 255, 258 (4th Cir.2001); *Imperial v. Suburban Hosp. Ass'n,* 37 F.3d 1026, 1029 (4th Cir.1994), we think plaintiff's argument that only such conduct is covered goes too far. First, when describing allowable bases for a professional review action, the statute begins with the critical term "competence." 42 U.S.C. § 11151(9). A physician's competence can be implicated by conduct outside a health care facility if there is a clear nexus between that conduct and the ability to render patient care. Second, the statute says "professional conduct" rather than "conduct in the course of medical practice" or "conduct that occurs in the hospital." Tellingly, therefore, Congress chose to use language that was somewhat broader than the more specific formulations plaintiff suggests. Moreover, the statutory definition includes a parenthetical defining "professional conduct" to include "conduct [which] affects or *could affect* adversely the health or welfare of a patient or patients." 42 U.S.C. § 11151(9) (emphasis added). This parenthetical clearly implies that the term "professional conduct" is not limited to past medical conduct that has already affected patient welfare. Instead, HCQIA immunity allows hospitals to take prophylactic measures that need not involve proof of improper conduct beyond a reasonable doubt so long as statutory procedures designed to protect the reputation and livelihood of the physician have been observed. In short, nothing in the statute requires peer review committees to wait until

medical disaster strikes.

Contrary to plaintiff's position then, HCQIA immunity may protect review actions based on conduct that has occurred outside of the hospital, but could realistically occur or affect treatment in the hospital. At some point, a peer review committee could surely conclude that it was only a matter of time before erratic or destructive behavior outside the medical setting began to manifest itself in patient care. If plaintiff's view were accepted, however, peer review committees would never under any circumstances be permitted to conclude that even the most advanced cases of alcohol addiction, illegal substance abuse, incipient dementia, or, as here, sexual misconduct toward children on the part of someone with a pediatric practice could affect professional "competence." 42 U.S.C. § 11151(9). Nor does the immunity depend, as plaintiff suggested at argument, upon whether the peer review decision required the application of medical expertise. The line between strictly medical and non-medical expertise would be a difficult one to draw (must the medical expertise relate to the physician's conduct or condition, the nature of the physician's practice, or the connection between the two?). Clearly the "competence" of a physician may be affected by arguably non-medical difficulties which are manifested outside the hospital: a hopelessly alcoholic physician or one adjudged to be mentally incompetent could only by happenstance render competent patient care. Most importantly, the statute did not adopt plaintiff's

proposed "medical expertise" standard. Adopting a strict line between professional and private conduct, or one based on the need for medical expertise, would improperly restrict the scope of HCQIA immunity and thereby involve the courts unduly in matters of hospital governance. Congress struck a careful balance between protecting physicians who are subject to professional review actions and providing immunity that encourages peer review and protects patients. Plaintiff's view of the statute compromises the latter goal.

At the other end, the hospital defendants urge us to adopt a broad interpretation of "professional review action" that encompasses almost any action based on conduct that might, in the peer review body's opinion, one day affect patient care. Defendants argue that because the whole purpose of HCQIA was to encourage peer review, Congress meant to provide an expansive grant of immunity.

The breadth of defendants' argument ignores the limiting language of the statute. It can be argued, of course, that almost any form of private misconduct may have some conceivable impact on a physician's performance, but no fair reading of the statute (with its emphasis upon competence and professional conduct) would indicate Congress intended to go nearly so far. Human beings are not smooth and rounded pebbles, but often contradictory in their habits and traits. A surgeon whose personal life might not bear close scrutiny may nonetheless save lives with his talents in the

operating room.

Giving peer review bodies the discretion to suspend staff privileges and report physicians for largely private defalcations is thus to arm those reviewers with a club that Congress did not provide. Defendants' view poses the risk that driving infractions, messy divorces or custody battles, tax or financial difficulties only tenuously or speculatively related to medical competence might fall within the purview of peer review. But this view is untenable. In no sense did Congress mean to encourage fishing expeditions into private behavior. A "professional review action" requires that the record reflect a clear nexus between the basis for an "action" or "recommendation" and a physician's medical practice. 42 U.S.C. § 11151(9). For the statute, notwithstanding its generous protections for peer review, imposes limits on the definition of "professional review action." The statute uses the word "professional"-a term that connotes the opposite of "personal"-and further emphasizes that there are limits on "professional review actions" by explicitly listing bases for actions which are outside of the definition, *see*42 U.S.C. § 11151(9)(A)-(E), including "any other matter that does not relate to the competence or professional conduct of a physician." *Id.* at § 11151(9)(E). Defendants' all-encompassing interpretation of the immunity would, like plaintiff's narrow restriction of it, upset the balance Congress struck.

B.

Both sides therefore advance interpretations that are too rigid-they treat this as an all-or-nothing matter. But we decline to adopt the absolute rule of either side in resolving the matter before us. In this case, there exists a clear nexus between the alleged sexual misconduct and plaintiff's medical practice. We do not infer such a nexus from the representations of the parties, for the record itself demonstrates a connection between the basis for plaintiff's suspension and his medical practice such that the hospital legitimately feared for patient well-being. While it would serve the interest of no one to lay bare all the details and disputes surrounding the conduct at issue, the record indicates that WRH suspended plaintiff out of a concern that he might sexually abuse child patients in the course of his practice. As the district court noted, "[t]he office of the clerk of the Family Court had provided Mr. Hales, Chief Executive Officer of the Hospital, with documents regarding the alleged sexual abuse." JA 649. The MEC reviewed materials from DSS evidencing sexual abuse, including the DSS investigation report concluding that there was a preponderance of evidence that plaintiff and his wife had sexually abused the child, drawings by the child, and statements made by the child to her therapist, forensic interviewer, and DSS caseworker. JA 905-52. The Hearing Committee Report stated that plaintiff's privileges were suspended based on DSS's sexual abuse allegations, the prior Family Court finding of child abuse and neglect, and "the

fact that [plaintiff] has the ability to take care of minor children within the hospital." JA 880. The Hearing Panel emphasized the "intimate relationship between physician and patient" and its concern for patient safety. JA 881.

Juberg, Hales, and members of the Medical Executive Committee each testified that they were concerned that plaintiff was a threat to patients, most notably children, at the hospital. Even a member of the MEC who did not think plaintiff's suspension was warranted stated that the suspension was not unreasonable because people "were genuinely concerned about the safety and welfare of the children in the community." JA 432. According to Juberg, the hospital considered limiting plaintiff's privileges to adult patients and prohibiting him from treating children, but ultimately didn't adopt this solution because it believed that "with his history of violating hospital policy, and because [WRH is] such a small institution and had really no way of policing or monitoring his goings on," simply limiting plaintiff's privileges "would still not protect the patients at the hospital." JA 707. He emphasized that "[w]e couldn't be sure that he would not have contact with children." *Id.* The same conclusion was reflected in Hales' comment that "[m]y main concern was for children." JA 720. A member of the Board of Directors declared that the "Board felt that upholding the suspension was the only reasonable and prudent option we had to ensure the safety of the patients at the Hospital." JA 838. And at oral argument, plaintiff's counsel

confirmed a crucial point: that plaintiff treated children at the hospital.

Certainly the hospital could have considered the relationship between the sexual abuse allegations and plaintiff's pediatric practice with more particularity, but there is ample evidence that those involved in plaintiff's peer review action recognized the potential for plaintiff to harm patients. The hospital feared that child abuse could occur on its watch and therefore was steering between two forms of potential civil liability: liability for child sexual abuse and liability for suspending a physician.

To be sure, there will be close cases surrounding the scope of HCQIA immunity. But that should hardly be surprising. The statutory test that a professional review action must be "based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients),"42 U.S.C. § 11151(9), presupposes a certain number of close calls. That is the case when any general standard is applied to the particular. But the entire purpose of an immunity provision is to afford some discretionary latitude to decision makers to make close calls unhaunted by the specter of civil liability. *See Elder v. Holloway*, 510 U.S. 510, 514, 114 S.Ct. 1019, 127 L.Ed.2d 344 (1994) ("The central purpose of affording public officials qualified immunity from suit is to protect them 'from undue interference with their duties and from potentially disabling threats of liability.' ").

It may not help therefore to posit future close hypothetical cases in the abstract, for matters come before decision makers in a far more concrete and factually variegated form. No single peer review proceeding precisely replicates another. Moreover, peer reviewers will not as a practical matter be preoccupied with whether something arose in a medical or nonmedical setting, but whether it is of a sufficient dimension to plainly affect a doctor's "competence" to practice medicine. In other words, it would prove problematic to chop the statutory standard into judicially fashioned boxes or categories. Rather, we should let the statutory test of "competence" stand simpliciter. In this case, the hospital conducted lengthy proceedings and saw the matter through three levels of review in what was manifestly an effort to determine plaintiff's "competence" to practice medicine. Whether or not we would have made the same decision ourselves is not the point. Any statutory standard inescapably involves some difficult exercises in judgment and to deny decision makers the right to exercise judgment in close cases is to defeat the purpose of immunity.

There are of course distinct limits on the scope of HCQIA immunity, but where as here the record reflects a clear nexus between the basis for plaintiff's suspension (evidence of child sexual abuse) and his medical practice (involving children) such that the hospital legitimately feared that plaintiff might harm child patients, it can be said that the review action was based on plaintiff's "competence" to treat children. 42 U.S.C. §

11151(9). And conversely, it cannot be said that the review action was based on a "matter that does not relate to the competence or professional conduct of a physician." *Id.* at § 11151(9)(E). The hospital's action therefore falls within the scope of HCQIA immunity.

C.

Having concluded that WRH's action is a "professional review action," we turn to the remaining requirements for HCQIA immunity. There is a statutory presumption that a professional review action meets the requirements for immunity unless the presumption is rebutted by a preponderance of the evidence. 42 U.S.C. § 11112(a).

Under § 11112(a)(1), the review action must be taken "in the reasonable belief that the action was in the furtherance of quality health care." There is ample evidence that WRH took the professional review action to protect child patients from sexual abuse.

Under § 11112(a)(2), the review action must be taken "after a reasonable effort to obtain the facts of the matter." The hospital engaged in a three-tier review of the initial summary suspension (the Medical Executive Committee, the Hearing Panel, and the Board of Directors). At every level, the members reviewed the evidence collected by DSS, heard witnesses, and gave plaintiff an opportunity to present evidence and cross-examine adverse

witnesses. In fact, the Hearing Panel held open the record for two months so that plaintiff could present additional evidence, and it ultimately produced a 114-page transcript, 70 pages of exhibits, and a detailed report including findings of fact based on the specific evidence considered. The Board even met twice so that plaintiff could present additional evidence.

Under § 11112(a)(3), the hospital must provide plaintiff "adequate notice and hearing procedures" that are further specified in § 11112(b). WRH satisfied these requirements. Plaintiff contends that WRH did not provide an adequate hearing because members of the Hearing Panel had previously participated in the MEC vote. We reject this argument because it is not based on the statutory requirement, which was satisfied, that the Hearing Panel consist of "individuals who are appointed by the entity and are not in direct economic competition with the physician involved."§ 11112(b)(3)(A)(iii). Moreover, plaintiff waived any right to object in this appeal because he did not object to the final composition of the Hearing Panel when it was convened. Plaintiff had previously objected to the initial composition of the Hearing Panel, had been notified of the final panel composition prior to the hearing, and knew firsthand who had participated in the MEC meeting which he had attended. Although he claims to have objected to the Hearing Panel composition at the Board of Director's review of his suspension, he had already waived any right to object by that point.

Under § 11112(a)(4), the review action must be taken "in the reasonable belief that the action was warranted by the facts known." There is evidence that defendants considered the facts and concluded that a suspension was necessary to protect patients due to plaintiff's pediatric practice and the difficulties of limiting his practice to adults. Plaintiff asserts that WRH should have proceeded by administrative suspension and not filed a detrimental report to the NPDB. However, plaintiff does not point to any requirement in HCQIA that a hospital must proceed in such a fashion. Absent such a requirement, where the action is reasonably warranted by the facts and otherwise meets HCQIA standards, it is valid. Administrative suspension simply represents another option for corrective action.

In sum, plaintiff has not met his burden of showing that the requirements in § 11112(a)(1)-(4) were not met. Therefore HCQIA immunity applies and insulates defendants from plaintiff's state law damages claims.

III.

We also note as an alternative basis for affirming the judgment that plaintiff's state law claims would fail in any event.

First, plaintiff claims that the hospital's conduct constitutes intentional infliction of emotional distress. This claim fails because the hospital's actions were hardly "so 'extreme and outrageous' so as to exceed 'all possible bounds of decency' " as

required to state a claim for IIED. *See Hansson v. Scalise Builders of S.C.*, 374 S.C. 352, 650 S.E.2d 68, 70 (2007) (quoting *Ford v. Hutson*, 276 S.C. 157, 276 S.E.2d 776, 778 (1981)). An attempt by the hospital to protect its minor patients, even if ultimately misguided, surely does not "exceed all possible bounds of decency."

Second, plaintiff claims that the hospital's peer review action amounts to tortious interference with plaintiff's existing and prospective contracts with the hospital, patients, and managed care plans. These claims fail because, even if plaintiff established the other elements of the torts, plaintiff has not presented evidence sufficient to establish that defendants' actions were without justification or were for an improper purpose. *See Camp v. Springs Mortgage Corp.*, 310 S.C. 514, 426 S.E.2d 304, 305 (1993) ("absence of justification" is an element of tortious interference with existing contracts); *Crandall Corp. v. Navistar Int'l Transp. Corp.*, 302 S.C. 265, 395 S.E.2d 179, 180 (1990) ("improper purpose" or "improper methods" is an element of tortious interference with prospective contracts); *see also*Restatement (Second) Torts § 767 cmt.f (whether interference promotes a "public interest" is a factor to determine whether interference is improper). The action taken here was not without justification nor is the protection of hospital patients an improper purpose. The fact that the hospital also observed HCQIA's safeguards of procedural fairness blunts plaintiff's claim that any interference with possible contractual

relationships was somehow tortious.

Third, plaintiff claims that defendants are liable for defamation. He argues that they knowingly filed a false report with the NPDB because they filed the report under the heading of "sexual misconduct" even though the hospital's action was based on mere allegations. Plaintiff is correct that the "basis for action" was listed as "Sexual Misconduct (D1)," but he fails to mention that this label came from the NPDB list of Basis for Action Codes and was used by the hospital to conform to NPDB formatting requirements. He also takes the phrase out of context. The report provides:

> Description of Act(s) or Omission(s) or Other Reasons for Action Taken: SERIOUS ALLEGATIONS OF SEXUAL MISCONDUCT OF A MINOR CHILD.
>
> Basis for Action: SEXUAL MISCONDUCT (D1)

When read in full, the report accurately states what happened: that the hospital suspended plaintiff's privileges due to serious allegations of sexual misconduct. The label "sexual misconduct" is not false; it is simply the most relevant general reporting category provided by the NPDB. Furthermore, we doubt South Carolina law would deny these defendants a defense of privilege when they could reasonably have believed that they were required by federal law to report plaintiff's

suspension. *See*42 U.S.C. § 11133 (health care entity is required to report "a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days"); *see also*42 U.S.C. § 11137(c) (providing immunity for HCQIA mandated reports made "without knowledge of the falsity of the information contained in the report").

Fourth, plaintiff claims that WRH is liable for violating the hospital bylaws under the theory of breach of contract. Plaintiff, however, points us to no South Carolina decision indicating that hospital bylaws create such a contractual relationship. In any event, plaintiff's claimed violation of Article VIII, § 4(a) of the bylaws (that members of the Hearing Panel had already voted on his suspension as members of the MEC) fails because, as discussed, plaintiff waived any rights to contest the composition of the Hearing Panel when he failed to object at the time the Panel was convened. *See Pruitt v. South Carolina Medical Malpractice Liability Joint Underwriting Ass'n,* 343 S.C. 335, 540 S.E.2d 843, 845 (2001) (waiver can be implied by party's conduct).

Plaintiff also alleges that WRH breached Article VII, § 2 of the bylaws by suspending him when it was not immediately necessary. Section 2 gives the Chairman of the MEC authority to summarily suspend privileges "whenever action must be taken immediately in the best interest of patient care." This claim fails because, given what Juberg knew at the time of his decision and the

difficulties of simply limiting plaintiff's practice to adults, it was reasonable for him to believe that he needed to suspend plaintiff's medical privileges to protect patients. For much the same reasons, plaintiff's claim that defendants are liable for these breaches under the theory of promissory estoppel also fails.

Fifth, plaintiff claims that WRH's "negligent sham peer review" violates the South Carolina Unfair Trade Practices Act's prohibition on "[u]nfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce." S.C.Code § 39-5-20(a). This claim fails for several reasons. First, plaintiff has not shown that the peer review was either "an unfair method of competition" or a "deceptive act or practice." The claim also fails because WRH's peer review action was not taken "in the conduct of any trade or commerce" as defined by S.C.Code § 39-5-10(b) since it did not occur in the conduct of "advertising, offering for sale, sale or distribution of any services and any property ... and any other ... thing of value." Instead, the peer review action was an internal hospital review taken to protect patients. *See Foggie v. CSX Transportation, Inc.*, 313 S.C. 98, 431 S.E.2d 587, 591 (1993) (holding that refusal to reinstall railroad crossing due to concern about crossing accidents was not the "conduct of trade or commerce").

Sixth, plaintiff claims that defendants are liable for civil conspiracy. This claim fails because a civil conspiracy must involve two or more legal entities,

Lawson v. South Carolina Dep't of Corr., 340 S.C. 346, 532 S.E.2d 259, 261 (2000), but defendants are one legal entity when engaging in peer review. *See Oksanen v. Page Mem'l Hosp.*, 945 F.2d 696, 702-03 (4th Cir.1991) (en banc) (staff members act as agents of the hospital during peer review). Plaintiff has also failed to show how the formal peer review process was "conspiratorial" in any real sense of the word, and plaintiff's allegations that Hales and Juberg were acting independently of the hospital for their own economic interests is on this record little more than speculation.

IV.

Plaintiff also alleges that WRH is liable for damages under 42 U.S.C. § 1983 for depriving him of his medical practice in violation of the Due Process Clause of the Fourteenth Amendment. HCQIA does not provide immunity from damages for claims made under the Civil Rights Acts. *See*42 U.S.C. § 11111(a)(1). This claim nonetheless fails for two reasons: (1) plaintiff failed to state a § 1983 claim because WRH's action was not state action,[3] and (2) plaintiff's substantive and procedural due process claims falter on the merits.

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[3] The same analysis applies to whether an action was taken "under color of state law" as required by § 1983 and whether the action was state action. *See Lugar v. Edmondson Oil Co., Inc.*, 457 U.S. 922, 935, 102 S.Ct. 2744, 73 L.Ed.2d 482 (1982)

A.

Plaintiff claims that WRH's suspension of his privileges is state action because the hospital's Board of Directors is nominated by the county delegates to the state legislature and ratified by the Governor; two county representatives are ex-officio members of the Board; the hospital receives state and county funds; and the hospital receives funds through Medicaid and the South Carolina State Plan under Title XIX of the Social Security Act as a public hospital. These facts do not make WRH's suspension of plaintiff's staff privileges state action.

WRH is currently incorporated as a private non-profit corporation under S.C.Code § 33-31-101 *et seq.* Previously, the hospital was Williamsburg County Memorial Hospital and was organized as a tax exempt Regional Health Services District under S.C.Code § 44-7-2010 *et seq.* It became a private hospital on October 1, 2001, when the assets of Williamsburg County Memorial Hospital Public Service District were transferred to defendant corporation WRH in accordance with

South Carolina law.[4] *See* S.C.Code § 4-9-82. This does not end our inquiry, however.

Under *Modaber v. Culpeper Mem'l Hosp., Inc.*, 674 F.2d 1023 (4th Cir.1982), a private entity's action can constitute state action if " 'there is a sufficiently close nexus between the State and the challenged action of the regulated entity that the action of the latter may fairly be treated as that of the State itself,' " but "state involvement without state responsibility cannot establish this nexus." *Id.* at 1025 (quoting *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 351, 358, 95 S.Ct. 449, 42 L.Ed.2d 477 (1974)). The state is deemed responsible for the private entity's action "if the private party acts (1) in an exclusively state capacity, (2) for the state's direct benefit, or (3) at

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[4] For this reason, plaintiff's arguments based on statements made prior to October 2001 and those premised on the notion that WRH is a Regional Health Services District are without merit. Plaintiff argues that the reincorporation does not change the status of the District under S.C.Code § 44-7-2130 which provides: "The reincorporation under Article 16, Chapter 7, Title 44 of the 1976 Code of any public hospital corporation that heretofore has been designated as the agency of a county ... in no way impairs or invalidates this designation and the reincorporated public hospital corporation shall continue as such just as if it had not been so reincorporated." This argument fails because the provision only applies when a District is reincorporated as a "public hospital corporation," *see id.* at § 44-7-2150, and because it only applies to determine whether a District continues to receive special tax revenues from the local government. *Id.* at § 44-7-2130.

the state's specific behest." *Id.* Applying this framework in *Modaber,* we held that the hospital's receipt of federal Hill-Burton Act funds, its acceptance of Medicare and Medicaid patients, and its obligation to report privileging decisions to the state were not enough to make the state responsible for the hospital's privileging decision under *Jackson. Id.* at 1027.

In this case, most of plaintiff's arguments relate to WRH's receipt of government funds through various state and federal programs and therefore do not make WRH's suspension of plaintiff state action under *Modaber.* As noted previously, "the mere fact that the hospitals implement a governmental program does not establish the nexus which *Jackson* requires." *Id.* at 1026.

Plaintiff contends, however, that this case is distinguishable from *Modaber* because government funding is not the only factor that establishes a nexus between WRH's action and the state. Here, in addition, the Board of Directors is nominated by the county delegates to the state legislature and approved by the Governor, and two government officials (the county supervisor and a county representative) serve as ex-officio members of the Board.

These additional facts, however, do not make the state responsible for WRH's privileging decisions. The Governor's involvement with the Board ends after he approves the members, and plaintiff has not presented any evidence that the Governor has

used his authority to influence privileging decisions. The county representatives may attend the board meetings, but they do not have voting rights and were not present for the consideration of plaintiff's suspension. In fact, the members of the Board who voted were three local bankers and a school principal. Therefore, it cannot be said that the Governor or the county representatives were responsible for WRH's decision to uphold plaintiff's suspension. As in *Freilich*," the State plays no role whatsoever in the actual decision as to whether or not to terminate or reappoint any particular physician." 313 F.3d at 214 n. 3; *see also Watts-Means v. Prince George's Family Crisis Ctr.*, 7 F.3d 40, 43 (4th Cir.1993) (rejecting argument that county representative on board constituted state action because representative only had one vote and therefore could not determine the board's decision). Therefore, WRH's suspension of plaintiff's privileges is not state action.

B.

Plaintiff's substantive and procedural due process claims also fail on the merits. Plaintiff claims that WRH violated his substantive due process rights when it suspended his privileges based on "unproven allegations" and therefore is liable for damages resulting from, among other things, his lost practice, loss of reputation and dignity, loss of contracts, and emotional distress. Given the sheer number of tort-like claims plaintiff raises, it is easy to see through his attempt to make an end run around HCQIA immunity by turning § 1983

and the Due Process Clause into the "font of tort law" that the Supreme Court has consistently rejected. *See Paul v. Davis*, 424 U.S. 693, 701, 96 S.Ct. 1155, 47 L.Ed.2d 405 (1976); *Waybright v. Frederick County*, 528 F.3d 199, 204 (4th Cir.2008) (collecting cases). Moreover, WRH did not just suspend plaintiff on "unproven allegations." WRH engaged in a multi-stage review of evidence including reports from the child's therapist and social worker. Therefore, plaintiff cannot meet the high standard of proving that WRH's peer review process was "so 'arbitrary' and 'egregious' that it 'shocks the conscience,' " and is "unjustifiable by any government interest." *Waybright*, 528 F.3d at 205 (quoting *County of Sacramento v. Lewis*, 523 U.S. 833, 845-49, 118 S.Ct. 1708, 140 L.Ed.2d 1043 (1998)).

Plaintiff also alleges that WRH did not provide him adequate procedures when it deprived him of his property right in his medical practice. Plaintiff's claim fails because the procedures WRH afforded him exceed the constitutional threshold established by *Mathews v. Eldridge*, 424 U.S. 319, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976). Plaintiff was notified of the allegations against him, given ample opportunity to present evidence, allowed to call and cross-examine witnesses, and was represented by counsel throughout. There was no procedural due process violation.

V.

The loss of clinical privileges is no small matter for

a physician, but we do not believe the hospital treated it as such. The proceedings here were lengthy and the procedures were fair. Peer review can be a thankless and time-consuming task for those involved, but also one that is necessary to uphold the profession's ultimate obligations not only to its members but to the patients that it serves. To put the parties in this case through further litigation runs the risk of working an injustice of its own, not simply on the individuals involved but on prospective peer reviewers who would henceforth avoid such service at all costs. Such a development would, of course, defeat the entire purpose of the Health Care Quality Improvement Act.

For the foregoing reasons, the judgment of the district court is

AFFIRMED.

FILED: September 21, 2007

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF SOUTH CAROLINA FLORENCE DIVISION

Blake H. Moore, MD, FACS, Individually Kingstree Surgical Associates, LLC,	)	
Plaintiffs,	)	Civil Action No. 4:05-2940-TLW
vs.	)	
Williamsburg Regional Hospital, John Hales, Breton Juberg, MD, Evelyn Ansa, MD, Joel Bonaparte, MD, Bernadette Bonaparte, MD, Kenneth Johnson, MD, Steve Corey, DPM, Michelle Corey-Butterworth, DPM, Kevin Springle, MD, Gilbertas Rimkus, MD, Jointly and Severally,	)	
Defendants.	)	

ORDER

I. FACTUAL ALLEGATIONS

The plaintiff, Blake H. Moore, is a general surgeon and former Chief of Surgery at Williamsburg Regional Hospital ("Williamsburg") ("hospital") ("defendant") in Kingstree, South Carolina. (Doc. #1). He filed this action against the hospital asserting claims related to suspension of his medical staff privileges. From June 2000 through early 2002, the plaintiff raised concerns about the hospital's patient quality care that apparently resulted in sanctions against the hospital. (Doc. #17). The plaintiff asserts that he also sought regulatory action against the hospital when an unidentified specimen of human tissue was discovered in the operating room. (Doc. #17). The plaintiff claims

that he was later ostracized and harassed by the hospital and its staff members. (Doc. #17).

During this same time, the plaintiff's three adopted children were taken into protective custody by the Department of Social Services ("DSS") as a result of allegations against the plaintiff's wife relating to excessive corporal punishment. (Doc. #17). The plaintiff was named as a codefendant although he was not accused of the allegations therein. (Doc. #17). However, a significant additional allegation of sexual abuse, implicating Dr. Moore and his wife, was made by one of the children after that child was taken into protective custody. (Doc. #35). The defendant Williamsburg obtained a copy of the complaint filed by DSS, and several days thereafter,

suspended the plaintiff's clinical privileges. (Doc. #35). The privileges were later constructively revoked in a hearing. (Doc. #17). There had been no resolution of the matter related to the plaintiff's children at the time of the suspension. The plaintiff appealed the suspension ruling to the hospital's Board of Directors, also objecting to the composition of the hearing panel. (Doc. #17). The Board upheld the panel's decision. The hospital then submitted a report of the allegations to the National Practitioner Data Bank. (Doc. #17).

On July 11, 2005, the Department of Social Services' action related to the plaintiff's children was dismissed. The plaintiff's wife died during this time period. (Doc. #17). The plaintiff, who had been working at Providence

Hospital in Columbia, South Carolina in the interim, requested that his privileges be reinstated with Williamsburg Regional Medical Center in August 2005. (Doc. #35). While at Providence, Dr. Moore, according to the record, did not become a member of the active staff but remained on probationary status. The hospital asked that the plaintiff provide a report from Providence Hospital about his employment. (Doc. #35). The report was never provided to Williamsburg. (Doc. #35). As a result, the Board of Directors at Williamsburg Hospital refused to reinstate the plaintiff's privileges. (Doc. #17). The plaintiff filed suit on October 14, 2005. (Doc. #1). He later moved to dismiss several claims against the defendant, leaving the following causes of action 42 U.S.C. § 1983, Intentional

Infliction of Emotional Distress, Tortious Interference with Existing and Prospective Contractual Relationships, Defamation, Breach of Contract, Promissory Estoppel, Unfair Trade Practices, and Civil Conspiracy. (Docs. #'s 1, 23, 38). The plaintiff asserts that he is unable to admit or provide surgical care to his patients, and thus, is financially devastated. (Doc. #17). Additionally, he claims to have lost his professional referral base, unique patient population, and is rapidly losing the surgical skills necessary to engage in meaningful employment. (Doc. #17). The plaintiff also alleges he is considering filing for bankruptcy. (Doc. #17).

On February 15, 2007, the defendants filed a motion for summary judgment. (Doc.

#66). On March 27, 2007, the plaintiff responded and filed a cross motion for summary judgment on the 42 U.S.C. § 1983 claim. (Attachments to Doc. #76). On April 27, 2007, the defendants replied to plaintiff's response, and responded to plaintiff's Motion for summary judgment on the § 1983 cause of action. On May 31, 2007, the plaintiff replied to defendants' memorandum in opposition to the cross motion for summary judgment on the § 1983 cause of action. On June 14, 2007, this Court held a hearing on the motions for summary judgment. This case is now ripe for disposition.

II. SUMMARY JUDGMENT STANDARD

In a motion for summary judgment, the moving party bears the burden of showing summary judgment is proper. Summary

judgment is proper if there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P.56(c); Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986). Summary judgment is proper if the non-moving party fails to establish an essential element of any cause of action upon which the non-moving party has the burden of proof. Celotex, 477 U.S. at 322. Once the moving party has brought into question whether there is a genuine issue for trial on a material element of the non-moving party's claims, the non-moving party bears the burden of coming forward with specific facts which show a genuine issue for trial. Fed.R.Civ.P. 56(e); Matsushita Electrical Industrial Co., Ltd. v. Zenith Radio Corp., 475 U.S. 574 (1986). The non-moving party must

come forward with enough evidence, beyond a mere scintilla, upon which the fact finder could reasonably find for it. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-48 (1986). The facts and inferences to be drawn therefrom must be viewed in the light most favorable to the non-moving party. Shealy v. Winston, 929 F.2d 1009, 1011 (4th Cir. 1991). However, the non-moving party may not rely on beliefs, conjecture, speculation, or conclusory allegations to defeat a motion for summary judgment. Barber v. Hosp. Corp. of Am., 977 F.2d 872, 874-75 (4th Cir. 1992) The evidence relied on must meet "the substantive evidentiary standard of proof that would apply at a trial on the merits." Mitchell v. Data General Corp., 12 F.3d 1310, 1316 (4th Cir. 1993).

III. DISCUSSION

As previously stated, the following causes of action remain: 42 U.S.C § 1983 ("1983"), Intentional Infliction of Emotional Distress, Tortious Interference with Existing and Prospective Contractual Relationships, Defamation, Breach of Contract, Promissory Estoppel, Unfair Trade Practices, and Civil Conspiracy. The Court will first discuss the plaintiff's state law claims in accordance with the Healthcare Quality Improvement Act of 1986 ("HCQIA"), and will then discuss the plaintiff's cause of action pursuant to § 1983.

A. HCQIA ANALYSIS

All of the state law claims hinge upon an analysis of the Hospital's peer review process under the Health Care Quality Improvement Act

of 1986 ("HCQIA") ("Act").[1] HCQIA grants limited immunity to professional review bodies, such as hospitals, for professional review actions that satisfy the Act's reasonableness and due process standards, Included in the Act is a statutory presumption of compliance which serves to shift the burden of proof to the physician plaintiff. The standard, at this stage in the proceeding, is whether a reasonable jury, viewing the facts in the best light for the plaintiff, could conclude that the plaintiff has shown by a preponderance of the evidence that the defendants' actions failed to satisfy the

[1] The Court notes the caption includes as a plaintiff Kingstree Surgical Associates, LLC. To the extent that there has been argument on its behalf, the Court concludes the application of HCQIA serves to grant immunity in favor of the defendants from damages by this entity on the state causes of action.

HCQIA standards. Gabaldoni v. Washington Cty. Hosp., 250 F.3d 255, 260 (4th Cir. 2001).[2]

HCQIA extends this special grant of immunity from damages whenever a professional review action is taken: (1) in the reasonable belief that the action was in furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort

[2] A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence. 42 U.S.C. § 11112.

to obtain facts and after meeting the requirement of section three. 42 U.S.C. § 11112.

In order for immunity to attach to the peer review undertaken, there must be a "reasonable belief" that the action was taken to further quality patient care. 42 U.S.C. § 11112(a)(1). The Fourth Circuit Court of Appeals described the reasonableness standard as one that "embodies the discretion that health care professionals have traditionally exercised in determining whether or not their peers meet a requisite level of professional competence." Freilich v. Upper Chesapeake Health, Inc., 313 F.3d 205, 212. This Court applies an objective test which looks to the "totality of the circumstances" in determining whether a professional review action was "undertaken in

the reasonable belief that quality health care was being furthered." Imperial v. Suburban Hops. Assoc., 37 F.3d 1026, 1030 (4th Cir. 1994).

The record reflects that the peer review was undertaken in the reasonable belief that quality health care was being furthered. At the time of the peer review, there were serious and documented allegations brought by the South Carolina Department of Social Services that the plaintiff's adopted children had been sexually abused. The office of the clerk of the Family Court had provided Mr. Hales, Chief Executive Officer of the Hospital, with documents regarding the alleged sexual abuse. (Doc. #66, Ex. A). In reviewing the documents, the Hospital learned that Dr. Moore and his wife lost custody of their three adopted children in a prior

Family Court case, the Family Court had made a prior fining of abuse and neglect against Dr. Moore and his wife, and DSS further alleged that an adopted daughter was sexually abused before being taken into foster care. Hales Aff. at ¶¶ 7-8(Ex. A). The 2004 DSS Complaint revealed that the allegations of sexual abuse against Dr. Moore and his wife arose from information provided by the adopted daughter to her caseworker. Id. In his deposition, Dr. Juberg, Chief of the Medical Staff, stated that the hospital had "a duty to protect [its] patients. And again, with the serious nature of these allegations, if even one patient was harmed with our knowledge or that potential, we had a duty to act." (Ex. L) (Juberg Dep. at P.64, L.23; P.65, L.8). In his deposition, Mr. Hales stated "it was

a suspension to mitigate the risk and protect our patients from any quality care issues." (Ex. M) (Hales Dep. at P.37, L.24; P.38, L.7). The record is replete with affidavits and deposition testimony from Dr. Moore's peers supporting the decision as one that was at th very least "reasonable" and out of concern for the welfare and safety of the children whom may be treated at the hospital.[3] Based upon the seriousness of the allegations, the evidence relied upon by the defendants, the supporting affidavits and depositions, the record reflects that the peer review action was undertaken in a reasonable belief that health care was being furthered. Looking "objectively at the totality of the

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[3] Plaintiff's expert conceded that the decision to suspend Dr. Moore was a decision over which reasonable minds could differ. (Ex. T) (Huntoon Dep. at P. 167, LL. 6-10).

circumstances" there was enough evidence against Dr. Moore for the Hosptial to reasonably conclude that it was furthering the quality of health care in terminating his privileges. Imperial v. Suburban Hops. Assoc., 37 F.3d 1026, 1030 (4th Cir. 1994).

In order for the special grant of immunity to attach, the second element requires there must have a "reasonable effort to obtain the facts of the matter." HCQIA 11112(a)(2). The record reflects that there was a reasonable effort to obtain the facts of the matter. The Board of Directors, the ultimate decision-maker in a peer review action, is entitled to rely upon an investigation conducted during the previous levels of the peer review process. Gabaldoni, at 261-62. It is clear from the record that

"reasonable efforts" were made to obtain the facts of the matter. Id.

Dr. Juberg obtained the DSS file from the South Carolina Family Court, reviewed it, and then summarily suspended Dr. Moore's privileges. Subsequently, Executive Committee of the Medical Staff ("MEC") considered the suspension. The MEC had the DSS file for consideration, and in addition, heard from Dr. Moore. After the MEC upheld the suspension, there was a full blown fact-finding hearing, and review of the MEC's decision, by an Ad Hoc Hearing Committee. At this hearing, Dr. Moore was represented by an attorney. Dr. Moore and the MEC had an opportunity to present any evidence each deemed relevant to this matter including an opportunity to present witnesses

and to cross-examine adverse witnesses. At the conclusion of the presentation of testimony, the Hearing Committee left open the hearing record to allow Dr. Moore and his counsel the opportunity to submit additional documents for the panel's consideration. Two months later, the panel deliberated and produced a detailed report indicating the evidence relied upon in making their determination. The hearing proceeding generated a 114-page transcript with approximately 70 pages of exhibits. Ad Hoc Hearing Comm. Report (Ex. Q). Dr. Moore appealed the recommendation of the Hearing Committee to the Board of Directors of the Hospital. An appellate review by the Board was convened on April 11, 2005, and at that review Dr. Moore's counsel offered oral argument in

support of ending the suspension. Finally, on April 18, 2005, the Board reconvened to receive additional information from Dr. Moore, to deliberate, and to vote. This Court concludes that it was reasonable for the defendants to rely on the reports and investigations of the various committees in rendering its decision because "the totality of the process leading up to the Board's professional review action" evidenced a reasonable effort to obtain the facts of the matter. Gabaldoni, at 261 *citing* Mathews v. Lancaster General Hosp., 87 F.3d 624, 637 (3d Cir. 1996). Therefore, the Court finds that no reasonable jury could find that the Board took action without a "reasonable effort to obtain the facts of the matter." Id.

As previously stated, the third standard requires that the professional review action must be taken "after adequate notice and hearing procedures are afforded to the physician or after such other procedures as are fair to the physician under the circumstances." 42 § U.S.C. 11112(a)(3). A "professional review action" does not occur under the Act until "an action or recommendation of a professional review body is taken or made in the context of a professional review activity...which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician." 42 U.S.C. § 11151(9). Here, the "professional review action" occurred when the MEC voted to suspend Dr. Moore's clinical privileges, not indefinitely, but until the allegations of

misconduct had been resolved. Here, there is no question as to the adequacy of notice of the hearing held before the Ad Hoc Hearing Committee. He received a list of witnesses the MEC expected to call. Dr. Moore had legal counsel present, was permitted to call his own witnesses, and allowed to cross-examine adverse witnesses.[4] The Board did not take any action prior to giving adequate notice and conducting hearing procedures that provided due process. Thus, this Court finds that no reasonable jury could conclude that the defendants failed to comply with the third requirement.

The final requirement that a peer review action must meet in order for the special grant of

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[4] Dr. Moore argues that the make up of the hearing panel was not in compliance with HCQIA. However, Dr. Moore was given the opportunity to object to members of the panel, and in fact, did so. The panel member whose presence he objected to was replaced. Subsequently, Dr. Moore consented to the composition of the panel.

immunity to attach is that the peer review action must be "undertaken in the reasonable belief that it was warranted by the facts known." 42 U.S.C. § 11112(a)(4). The Act provides deference to the hospital's governing board to weigh the evidence and make decisions about the termination of medical staff privileges. It is clear from the facts, known at the time the suspension decision was rendered, there was a reasonable belief that the action was warranted. In reviewing the documents, and after testimony, the Hospital learned that there had been a prior finding of abuse and neglect against Dr. Moore and his wife. DSS further alleged that their adopted daughter had been sexually abused before she was taken into foster care. In order to prevail on this final prong, a plaintiff

must show that the "facts relied upon for the decision were so obviously mistaken or inadequate that reliance upon them was unreasonable." Meyers v. Columbia/HCA Healthcare Corp., 341 F.3d 461, 471 (6th Cir. 2003). Based upon the evidence in the record, this Court concludes that the facts relied upon were not "obviously mistaken or inadequate" so that "reliance upon them was unreasonable." Id. To the contrary, the Court finds there was a proper investigation, with sufficient, reliable facts revealed, that formed the basis for the peer review action.

While suspended, Dr. Moore worked at Providence Hospital. On July 11, 2005, the Department of Social Services' action related to the plaintiff's children was dismissed.

Subsequently, Dr. Moore applied for reinstatement at Williamsburg Regional Hospital. The defendants requested credentialing information from Providence Hospital. Providence provided the information to Dr. Moore. Dr. Moore disagreed with the information Providence provided. Instead of providing that information to Williamsburg Hospital, he requested that he be immediately reinstated despite non-disclosure of his credentialing information. Mr. Hales felt that reinstating Dr. Moore without the credentialing information would be "irresponsible." (Ex. A) (Hales Aff. at P.39). Subsequently, the Board voted and decided not to reinstate the plaintiff. Under the circumstances, this Court gives deference to that decision, and does not conclude

this decision was unreasonable. The Court finds that there is no genuine issue of material fact regarding plaintiff's denial of reinstatement, and that the defendants are entitled to judgment as a matter of law. Thus, defendants' motion for summary judgment in connection with plaintiff's state causes of action relating to reinstatement of the plaintiff is **granted**. (Doc. #66).

Based on the foregoing, the Court **grants** defendants' motion for summary judgment (Doc. #66) as to plaintiff's state causes of action.

B. 42 U.S.C. § 1983

Having concluded that the defendants peer review action complied with the standards of HCQIA, the Court is left with plaintiff's § 1983

action.[5] Under 42 U.S.C. § 1983, a plaintiff must allege (1) that the defendant acted under color of a statute, ordinance, regulation, custom, or usage of a state (2) a deprivation of right, privilege, or immunity secured by the Constitution or laws of the United States, and (3) that the defendant subjected or caused the plaintiff to be subjected to such deprivation. In his motion for summary judgment, the plaintiff alleges that the defendants deprived him of his medical practice in violation of the procedural

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[5] The Court notes the caption includes as a plaintiff Kingstree Surgical Associates, LLC. The plain language of 42 U.S.C § 1983 states "every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, *any citizen of the United States or other person* within the jurisdiction thereof to the..." Therefore, the plaintiff Kingstree Surgical Associates, LLC may not bring a § 1983 cause of action. As such, the Court will discuss this claim as it pertains to Dr. Moore. However, to the extent plaintiff Kingstree Surgical Associates, Inc. seeks relief pursuant to § 1983 the Court concludes that the claim fails for the reasons discussed herein.

and substantive due process rights of the Fourteenth Amendment. The plaintiff alleges that the defendants caused the plaintiff such deprivation through a sham peer review process and by failing to reinstate the plaintiff while acting under color of state law. Unlike the proceeding HCQIA analysis, the Court applies the normal summary judgment standard to plaintiff's § 1983 cause of action.[6]

For purposes of this § 1983 claim, the Court first determines whether or not the defendants acted under color of state law. The parties dispute whether the defendant Williamsburg Regional Hospital is a state actor for § 1983 purposes. The problem in state action cases is that demarcation of spheres, public and

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[6] The summary judgment standard set forth on page 3-4 of this Order applies to the § 1983 cause of action.

private, is a dynamic process, and the boundaries between the two shift and are adumbrated by the various factual situations which are presented for review. Greco v. Orange Memorial Hosptial Corp., 513 F2d 873, 877 (5th Cir. 1975). The defendant Williamsburg Regional Hospital is a private, non-profit corporation. Williamsburg Regional Hospital was once a county facility, until the hospital became private in 2001. The Internal Revenue Service and South Carolina recognize the Hospital's private entity status. (Ex. AA). Thus, as Williamsburg Regional Hospital is a private entity the Court must determine whether the conduct of the hospital is attributable to the state, such that the defendants may be liable to plaintiffs for a § 1983 cause of action.

In Modaber, M.D. vs. Culpeper Memorial Hospital Inc., 674 F.2d 1023 (4th Cir. 1982), a physician brought a § 1983 cause of action against a hospital alleging that revocation of his clinical staff privileges deprived him of a valuable property right without affording procedural due process under the Fourteenth Amendment. In Modaber, the Court held that "the staff privileges decisions of a hospital which receives Hill-Burton Act funds, accepts Medicare and Medicaid patients and reports privileges revocations to state medical licensing authorities do not constitute 'state action.'" Id. at 1027. In reaching this conclusion the Court inquired "whether there is a sufficiently close nexus between the State and the challenged action of the regulated entity that the action of the latter

may fairly be treated as that of the State itself." Id. at 1025 *quoting* Jackson v. Metropolitan Edison Co., 419 U.S. 345, 351 (1974). State involvement without state responsibility cannot establish this nexus. Id. In Modaber, the court stated that a state becomes responsible for a private party's act if the private party acts (1) in an exclusively state capacity, (2) for the state's direct benefit, or (3) at the state's behest. Id. The court explained that the private party "acts in an exclusively state capacity when it 'exercises powers traditionally exclusively reserved to the state,' Jackson, 419 U.S. 352, for the state's direct benefit when it shares the rewards and responsibilities of a private venture with the state, *See* Id., 357-58, Burton v. Wilmington Parking Authority, 356 U.S. 725 (1961), and at

the state's specific behest when it does a particular act which the state has directed or encouraged." *See* 419 U.S. 354, 357; Modaber, 674 F.2d 1025. The Court will examine the plaintiffs' allegations within this framework.

The plaintiff has not established the first prong of the test for state action as set forth in Modaber. Although states may create and support hospitals, the business of running a hospital is not an activity "traditionally exclusively reserved to the State." Rockwell v. Cape Code Hosp., 26 F.3d 254, 258 (1st Cir. 1994) (quoting Rodriques v. Furtado, 950 F.2d 805, 813 (1st Cir. 1991)). The peer review process is not a prerogative of the state; hospitals have had a common law right to revoke staff privileges of physicians for good cause. Wong v. Stripling,

881 F.2d 200, 202 (5th Cir. 1989). Similarly, reinstatement of physicians is not a prerogative of the state.

The plaintiff has not established the second prong of the test for state action as set forth in Modaber. Neither the State nor the County receive any share of the profits generated by the defendant Williamsburg Regional Hospital.

The plaintiff has not established the third prong of the test for state action. The plaintiff asserts that defendant Williamsburg Regional Hospital is a state actor because the defendant is subject to state regulations, is licensed by the State, receives compensation through Medicare and Medicaid, and derives income and benefits from state, county, and city sources. Other

courts have held that such interaction between a private entity and state government is insufficient to establish that a hospital acted under color of state law. See, e.g., Rockwell, 26 F.3d at 258; Wheat v. Mass, 994 F.2d 273, 275-276 (5th Cir. 1993); Ross v. Hilltop Rehabilitation Hosp., 676 F. Supp. 1528 (D. Colo. 1987).

The plaintiff contends that the defendant is a state actor because Board Members are nominated by the county legislative delegation and affirmed by the Governor's Office. (Response to Doc. #66). Further, the plaintiff argues that county representatives are ex-officio members of the Board and the County Attorney attends all Board meetings. However, the mere presence of public officials on a hospital's board of directors does not itself render decisions by

the hospital state action. See Crowder v. Conlan, 740 F.2d 447, 452 (6th Cir. 1984). Important for analysis, the record reflects that the county does not have significant incidents of control over the Hospital's internal affairs. The public officials are not voting members of the Hospital's Board, and thus, they do not have authority to terminate clinical privileges or to reinstate physicians. The State officials do not make employment decisions or set forth the procedure by which the defendants hire or terminate employees. The facts reveal that the members who voted on the plaintiff's peer review action were three local bankers and a principal at a local school. (Hales Aff. At P.8) (Ex. BB). Peer review actions are internal affairs, reserved for the private actors of the facility, of which the

state takes no responsibility. The evidence in the record reflects that the defendants did not act in an exclusively state capacity, for the state's benefit, or at the state's behest during any process relating to the employment of the plaintiff.

Assuming that the Court did find "state action," plaintiff's claim would fail on the merits. Pursuant to Butler v. William and Mary, 121 Fed. Appx. 515 (4th Cir. 2005), to succeed with a substantive due process claim, the plaintiff would have to establish that the defendants acted "arbitrarily or egregiously" during the peer review action and reinstatement process. As previously discussed in the HCQIA analysis, the plaintiff has failed to do so. In order to succeed with a claim for a procedural due process

violation, the plaintiff must establish that the defendant failed to provide plaintiff the appropriate level of process under the circumstances. In light of the Court's ruling as to the peer review process under HCQIA, the Court concludes that the plaintiff is unable to meet that burden. Similarly, the plaintiff has failed to establish that the defendant failed to provide plaintiff the appropriate level of process during the reinstatement process.

Therefore, plaintiff's cross motion for summary judgment on the §1983 cause of action is **denied** (Attachment to Doc. #76) and the defendants' summary judgment motion on the §1983 cause of action is **granted**. (Doc. #66).

IV. CONCLUSION

Based on the foregoing, the Court finds that a reasonable jury could not conclude, viewing the facts in the best light of the plaintiff, that the plaintiff has shown by a preponderance of the evidence that the defendants' actions failed to satisfy the HCQIA standards. Gabaldoni v. Washington Cty. Hosp., 250 F.3d 255, 260 (4th Cir. 2001). Additionally, for the reasons stated herein, the defendants prevail on the §1983 cause of action. Therefore, the Court concludes plaintiff's motion for summary judgment as to the §1983 cause of action is **DENIED.** (Attachment to Doc. #76). The Court concludes the defendants' motion for summary judgment as to all causes of action is **GRANTED**. (Doc. #66).[7]

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[7]This Order renders any outstanding motions **MOOT.**

IT IS SO ORDERED.

S/Terry L. Wooten
Terry L. Wooten
United States District Judge

Florence, South Carolina

September 21, 2007

FILED: April 7, 2009

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 07-1966
(4:05-cv-02940-TLW)

BLAKE H. MOORE, MD, FACS, Individually and as the Personal Representative of the Estate of Angela Lynn Moore; KINGSTREE SURGICAL ASSOCIATES, LLC,

Plaintiffs – Appellants

v.

WILLIAMSBURG REGIONAL HOSPITAL; JOHN HALES; BRETON JUBERG, MD; EVELYN ANSA, MD; JOEL BONAPARTE, MD; BERNADETTE BONAPARTE, MD; KENNETH JOHNSON, MD; STEVE COREY, DPM; MICHELLE COREY-BUTTERWORTH, DPM; KEVIN SPRINGLE, MD; GILBERTAS RIMKUS, MD, Jointly and severally,

Defendants – Appellees

and

RAYMOND ALLEN, MD; BASHIR OBEIDOU, MD; MARION RIGGS, Jointly and Severally;

Defendants

Providence Hospital

Party in Interest

ORDER

The Court denies the petition for rehearing and rehearing en banc. No judge requested a poll under Fed. R. App. P. 35 on the petition for rehearing en banc.

Entered at the direction of the panel: Judge Wilkinson, Judge Duncan, and Judge Agee

For the Court

/s/ Patricia S. Connor, Clerk

Supreme Court, U.S.
FILED

09-30 JUL 02 2009

OFFICE OF THE CLERK
William K. Suter, Clerk

07-02-09

(2)

No. 09-30

IN THE
Supreme Court of the United States

BLAKE H. MOORE, M.D., *et al.*,

Petitioners,

v.

WILLIAMSBURG REGIONAL HOSPITAL; JOHN HALES; *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

SUPPLEMENTAL APPENDIX

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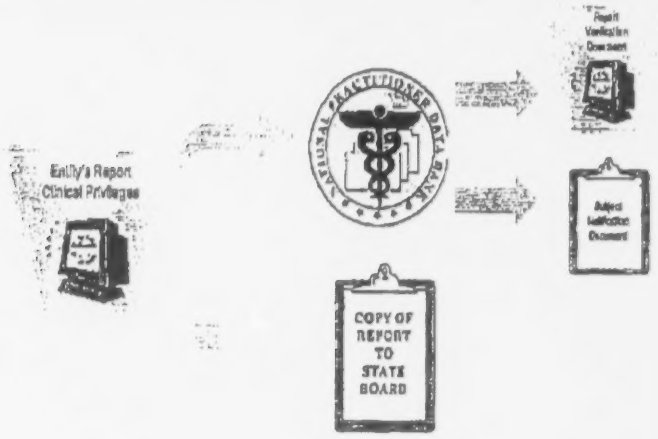
REPORTING ADVERSE CLINICAL PRIVILEGES ACTIONS



Reporting Adverse Clinical Privileges Actions

Health care entities must report adverse actions within 15 days from the date the adverse action was taken or clinical privileges were voluntarily surrendered. **The health care entity must print a copy of each report submitted to the NPDB and mail it to the appropriate State licensing board for its use.** The *Report Verification Document* that health care entities receive after a report is successfully processed by the NPDB should be used for submission to the appropriate State licensing board.

Reportable adverse clinical privileges actions are **based on a physician's or dentist's professional competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of a patient.** Hospitals and other eligible health care entities must report:

- Professional review actions that adversely affect a physician's or dentist's clinical privileges for a period of more than 30 days.
- Acceptance of a physician's or dentist's surrender or restriction of clinical privileges while under investigation for possible professional incompetence or improper professional conduct or in return for not conducting an investigation or reportable professional review action.

Adverse actions taken against a physician's or dentist's clinical privileges include reducing, restricting, suspending, revoking, or denying privileges, and also include a health care entity's decision not to renew a physician's or dentist's privileges if that decision was based on the practitioner's professional competence or professional conduct. **Health care entities may report such actions taken against the clinical privileges of other health care practitioners.**

Adverse actions involving censures, reprimands, or admonishments should not be reported to the NPDB. Matters not related to the professional competence or professional conduct of a practitioner should not be reported to the NPDB. For example, adverse actions based primarily on a practitioner's advertising practices, fee structure, salary arrangement, affiliation with other associations or health care professionals, or other competitive acts intended to solicit or retain business are excluded from NPDB reporting requirements.

See Table E-3 on page E-21 for more information on determining reportable actions for clinical privileges.

Hospitals and other health care entities must report revisions to previously reported adverse actions. For more information on revisions, see page E-5, Revision to Action, in the Types of Reports section.

Multiple Adverse Actions

If a single professional review action produces multiple clinical privileges actions (for example, a 12-month suspension followed by a 5-month probation), only one report should be submitted to the NPDB. The Adverse Action Classification Code for the principal action should be submitted on the AAR, and the narrative description should describe the additional adverse actions imposed.

A Revision to Action must be submitted when each of the multiple actions is lifted. (Following the previous example, a revision must be submitted when clinical privileges are reinstated with probation after the suspension, and another revision must be submitted when the probationary period ends.)

If an adverse action against the clinical privileges of a practitioner is based on multiple grounds, only a single report must be submitted to the NPDB. However, all reasons for the action should be reported and explained in the narrative. The reporting entity may select up to four Basis for Action codes to indicate these multiple reasons. Additional reasons should be summarized in the narrative description.

Denial of Applications

A restriction or denial of clinical privileges that occurs solely because a practitioner does not meet a health care institution's established threshold eligibility criteria for that particular privilege is not reportable to the NPDB.

Such restrictions or denials are not deemed the result of a professional review action relating to the practitioner's professional competence or professional conduct, but are considered decisions based on eligibility.

For example, if an institution retroactively changes the eligibility criteria for a particular clinical privilege, a physician that does not meet the new criteria will lose previously granted clinical privileges; this loss of privileges is not reportable to the NPDB.

Adverse clinical privileges actions reportable to the NPDB result from professional review actions relating to the practitioner's professional competence or professional conduct.

Withdrawal of Applications

Voluntary withdrawal of an initial application for medical staff appointment or clinical privileges prior to a final professional review action generally is not reportable to the NPDB. However, if a practitioner applies for renewal of medical staff appointment or clinical privileges and voluntarily withdraws that application while under investigation by the health care entity for possible professional incompetence or improper professional conduct, or in return for not conducting such an investigation or taking a professional review action, then the withdrawal of application for clinical privileges is reportable to the NPDB.

Investigations

Investigations should not be reported to the NPDB; only the **surrender or restriction of clinical privileges** while under investigation or to avoid investigation is reportable. This would include a failure to renew clinical privileges while under investigation.

A health care entity that submits an AAR based on surrender or restriction of a physician's or dentist's privileges while under investigation should have contemporaneous evidence of an ongoing investigation at the time of surrender, or evidence of a plea bargain. The reporting entity should be able to produce evidence that an investigation was initiated prior to the surrender of clinical privileges by a practitioner. Examples of acceptable evidence may include minutes or excerpts from committee meetings, orders from hospital officials directing an investigation, and notices to practitioners of an investigation.

Guidelines for Investigations

- An investigation must be carried out by the health care entity, not an individual on the staff.
- The investigation must be focused on the practitioner in question.
- The investigation must concern the professional competence and/or professional conduct of the practitioner in question.
- A routine or general review of cases is not an investigation.
- A routine review of a particular practitioner is not an investigation.
- An investigation should be the precursor to a professional review action.
- An investigation is considered ongoing until the health care entity's decision making authority takes a final action or formally closes the investigation.

Summary Suspension

A summary suspension is reportable if it is:

- In effect or imposed for more than 30 days.
- Based on the professional competence or professional conduct of the physician, dentist, or other health care practitioner that adversely affects, or could adversely affect, the health or welfare of a patient.
- The result of a professional review action taken by a hospital or other health care entity.

A summary suspension is often imposed by an individual, for instance, the chairman of a department. Commonly,

this action is then reviewed and confirmed by a hospital committee, such as a medical executive committee, as authorized by the medical staff bylaws. The suspension would then be viewed as a professional review action taken by the entity.

If the suspension is modified or revised as part of a final decision by the governing board or similar body, the health care entity must then submit a Revision to Action of the Initial report made to the NPDB.

If the physician, dentist, or other health care practitioner surrenders his or her clinical privileges during a summary suspension, that action must be reported to the NPDB. The action is reportable because the practitioner is surrendering the privileges either while under investigation concerning professional conduct or professional competence that did or could affect the health or welfare of a patient or in order to avoid a professional review action concerning the same.

Summary suspensions are considered to be final when they become professional review actions through action of the authorized hospital committee or body, according to the hospital bylaws.

The basis for this interpretation is that, pursuant to Part A of the *Health Care Quality Improvement Act* (42 U.S.C. §11112)(c)(2), a summary suspension is taken to prevent "imminent danger to the health of any individual."

The Act itself treats summary suspensions differently than other professional review actions: the procedural rights of the practitioner are provided for following the suspension, rather than preceding it. This reporting policy for summary suspensions is in keeping with the purpose of the Act, which is to protect the public from the threat of incompetent practitioners continuing to practice without disclosure or discovery of previous damaging or incompetent performance.

In establishing this policy on the reporting of summary suspensions, HHS assumes that hospitals use summary suspensions for the purpose stated in Part A of the Act: to protect patients from imminent danger, rather than for reasons that warrant routine professional review actions. HHS also emphasizes that this policy on summary suspension is solely for the purpose of reporting to the NPDB, and does not relate to the criteria for immunity under Part A of the Act.

Table E-3. Determining Reportable Actions for Clinical Privileges

Action	Reportable
Based on assessment of professional competence, a proctor is assigned to a physician or dentist for a period of more than 30 days. The practitioner must be granted approval before certain medical care is administered.	Yes
Based on assessment of professional competence, a proctor is assigned to supervise a physician or dentist, but the proctor does not grant approval before medical care is provided by the practitioner.	No
As a matter of routine hospital policy, a proctor is assigned to a physician or dentist recently granted clinical privileges.	No
A physician or dentist voluntarily restricts or surrenders clinical privileges for personal reasons; professional competence or professional conduct is not under investigation.	No
A physician or dentist voluntarily restricts or surrenders clinical privileges; professional competence or professional conduct is under investigation.	Yes
A physician or dentist voluntarily restricts or surrenders clinical privileges in return for not conducting an investigation of professional competence or professional conduct.	Yes
A physician's or dentist's application for medical staff appointment is denied based on professional competence or professional conduct.	Yes
A physician or dentist is denied medical staff appointment or clinical privileges because the health care entity has too many specialists in the practitioner's discipline.	No
A physician's or dentist's clinical privileges are suspended for administrative reasons not related to professional competence or professional conduct.	No
A physician's or dentist's request for clinical privileges is denied or restricted based upon assessment of clinical competence as defined by the hospital.	Yes

Examples of Reportable and Non-Reportable Actions

Example 1: A physician member of a hospital medical staff wishes to perform several clinical tests and procedures, but does not have the appropriate clinical privileges. The physician applies for an expansion of clinical privileges. The physician's Department Head and the Medical Staff Credentials Committee find that, based on their assessment of the physician's demonstrated professional performance, the physician does not have the clinical competence to perform the additional tests and procedures, and they recommend denial of the request for expanded clinical privileges. The hospital's governing body reviews the case, affirms the findings and recommendations, and denies the physician's request for expanded clinical privileges for reasons relating to professional competence.

The action is reportable because the denial of privileges adversely affects the clinical privileges of the physician for longer than 30 days.

Whether particular actions are reportable to the NPDB is often best determined by examining a hospital's medical staff bylaws, rules, and regulations with regard to provisions defining who is empowered to take a professional review action, what constitutes a professional review action that adversely affects the clinical privileges of a practitioner, and how that action relates to professional competence or professional conduct.